MISSISSIPPI CODE 1972

Annotated

Insurance
(83-1-1 to 83-85-21)

Title 83

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MISSISSIPPI CODE

1972

ANNOTATED

ADOPTED AS THE OFFICIAL CODE OF THE
STATE OF MISSISSIPPI
BY THE
1972 SESSION OF THE LEGISLATURE

VOLUME NINETEEN/NINETEEN A

INSURANCE

§§ 83-1-1 to 83-85-21

CONTAINING PERMANENT PUBLIC STATUTES OF MISSISSIPPI
TO THE END OF THE 2022 REGULAR LEGISLATIVE SESSION

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PREFACE

The Mississippi Code of 1972, which became effective on November 1, 1973, is the culmination of nearly four years of effort on the part of the Legislature, the Attorney General's office and the publishers, which brings together provisions of general statutory law having a common subject matter into a more orderly and logical framework of code titles and chapters, and employing a modern and effective section numbering system. A major by-product of the code revision will be the state-owned magnetic computer tape containing the Mississippi Code of 1972, which will be of invaluable assistance to the Legislature and to the state.

The enabling act for the code was a recommendation of the Mississippi State Bar, which resulted in the consideration and passage of Senate Bill 1964, Chapter 465, Laws of 1970, signed into law by Governor John Bell Williams.

The Code Committee provided for in that act was comprised of A. F. Summer, Attorney General, Heber Ladner, Secretary of State, Representative Edgar J. Stephens, Jr., Chairman, House Appropriations Committee, Senator William G. Burgin, Jr., Chairman, Senate Appropriations Committee, Representative H. L. Meredith, Jr., Chairman, House Judiciary "A" and Judiciary en banc Committees, Senator E. K. Collins, Chairman, Senate Judiciary "A" and Judiciary en banc Committees, Representative Ney McKinley Gore, Jr., Chairman, House Judiciary "B" Committee, and Senator William E. Alexander, Chairman, Senate Judiciary "B" Committee. In 1972, Representative Marby Robert Penton and Senator Herman B. Decell, Chairman of House and Senate Judiciary "B" Committees, respectively, became members of the Committee, replacing Representative Gore and Senator Collins, Senator Alexander having been appointed Chairman of Senate Judiciary "A" and Judiciary en banc Committees. The Deputy Attorney General, Delos H. Burks, served the Code Committee as Secretary. Special Assistant Attorney General Fred J. Lotterhos, under the supervision of the Attorney General, was assigned the principal responsibility for the supervision of the recodification, including the consideration and treatment of some 16,000 sections of code manuscript.

Final legislative approval was given to the Mississippi Code of 1972 by passage of Senate Bill 2034, Laws of 1972, which was signed by Governor William L. Waller on April 26, 1972.

The Code Committee is of the opinion that the recodification has been thoroughly and well accomplished, and will result in a greatly improved repository of the general statutory law of the state.

A. F. Summer
Attorney General

PUBLISHER'S FOREWORD

This newly compiled 2022 Replacement Volume 19 of the Mississippi Code of 1972 Annotated represents material appearing in the original 1973 Volume 19, and in bound volume 19 as it was replaced in 1991, 1999, and 2011, and in bound volume 19A as it was replaced in 1999 and 2011, as well as reflecting amendments, repeals, and new Code provisions enacted by the Mississippi Legislature through the 2022 Regular Session.

This volume contains the full text of Title 83 of the Mississippi Code of 1972 Annotated, as amended through the 2022 Regular Legislative Session.

Case annotations are included based on decisions of the State and federal courts in cases arising in Mississippi. Many of these cases were decided under the former statutes in effect prior to the enactment of the Code of 1972. These earlier cases have been moved to pertinent sections of the Code where they may be useful in interpreting the current statutes. Annotations to collateral research references are also included.

To better serve our customers by making our annotations more current, LexisNexis has changed the sources that are read to create annotations for this publication. Rather than waiting for cases to appear in printed reporters, we now read court decisions as they are released by the courts. A consequence of this more current reading of cases, as they are posted online on LexisNexis, is that the most recent cases annotated may not yet have print reporter citations. These will be provided, as they become available, through later publications.

This publication contains annotations taken from decisions of the Mississippi Supreme Court and the Court of Appeals and decisions of the appropriate federal courts. These cases will be printed in the following reporters:

Southern Reporter, 3rd Series
United States Supreme Court Reports
Supreme Court Reporter
United States Supreme Court Reports, Lawyers' Edition, 2nd Series
Federal Reporter, 3rd Series
Federal Supplement, 3rd Series
Federal Rules Decisions
Bankruptcy Reporter

Additionally, annotations have been taken from the following sources:

American Law Reports, 6th Series
American Law Reports, Federal 2nd Series
Mississippi College Law Review
Mississippi Law Journal

Finally, published Opinions of the Attorney General and opinions of the Ethics Commission have been examined for annotations.

A comprehensive Index appears at the end of this volume.

Visit the LexisNexis website at http://www.lexisnexis.com for an online bookstore, technical support, customer support, and other company information.

For further information or assistance, please call us toll-free at (800) 833-9844, fax us toll-free at 518-487-3584, e-mail us at customer.support@bender.com, or write to: Mississippi Code Editor, LexisNexis, 9443 Springboro Pike, Miamisburg, OH 45342.

September 2022 LexisNexis

User's Guide

This guide is designed to help both the lawyer and the layperson get the most out of the Mississippi Code of 1972 Annotated. Information about key features of the Code and suggestions for its more effective use are given under the following headings:

- — Advance Code Service
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- — Amendment Notes
- — Analyses
- — Code Status
- — Comparable Legislation from other States
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If you have a question not addressed by the User's Guide, or comments about your Code service, you may contact us by calling us toll-free at (800) 833-9844, faxing us toll-free at (800) 643-1280, e-mailing us at customer.support@bender.com, or writing to Mississippi Code Editor, LexisNexis, 9443 Springboro Pike, Miamisburg, OH 45342.

ADVANCE CODE SERVICE

Three times a year, at roughly quarterly intervals between delivery of Code supplement pocket parts, we publish the Mississippi Advance Code Service pamphlets. These pamphlets contain updated statutory material and annotations to Attorney General opinions, research and practice references, and recent court decisions construing the Code. Each pamphlet is cumulative, so that each is a "one-stop" source of case notes updating those in your Code bound volumes and pocket parts.

ADVANCE SHEETS

The Advance Sheets consist of a series of pamphlets issued in the spring. The series reproduces the acts passed by the Mississippi Legislature and approved by the Governor during the legislative session. Features include tables showing the impact of legislation on sections of the Mississippi Code of 1972 Annotated, and a cumulative index. These pamphlets enable the user to receive a preview of approved legislation prior to supplement availability, and serve as an excellent source of legislative history.

AMENDMENT NOTES

Every time a Code provision is amended, we prepare a note describing the effect of the amendment. By reading the note, you can ascertain the impact of the change without having to check the former statute itself.

Amendment notes are retained in the Supplement until the bound volume is replaced, at which time notes from all but the last two years are deleted.

Amendment notes are retained online indefinitely.

ANALYSES

Each title, chapter, and article appearing in a bound volume or supplement is preceded by an analysis. The analysis details the scope of the title, chapter, and article and enables you to see at a glance the content of the title, chapter, and article without resorting to a page-by-page examination in the bound volume or supplement.

CODE STATUS

The Mississippi Code of 1972 Annotated is Mississippi's official code and is considered evidence of the statute law of the State of Mississippi (see § 1-1-8). The Code was enacted by Chapter 394 of the Laws of 1972, which was signed by the Governor on April 26, 1972.

Title 1, Chapters 1 through 5 of the Code contain statutes governing the status and construction of the Code.

COMPARABLE LEGISLATION FROM OTHER STATES

Notes to comparable legislation from other states appear for uniform laws, interstate compacts, statutory provisions pertaining to reciprocity and cooperation with other states, and various important statutes of general interest. Other states' statutes that are similar in subject matter and scope to those of Mississippi are cited, generally, under the first section of the chapter or article to which they pertain. Occasionally, comparable legislation pertains to only one section, in which case it is cited under that section rather than at the chapter or article level.

See also *Federal Aspects*.

COURT RULES

The Mississippi Court Rules are published separately by LexisNexis in a fully annotated softcover volume which is replaced annually and supplemented semi-annually.

The Court Rules volume contains statewide rules of procedure of the state courts, the local rules of the United States district courts and bankruptcy courts for Mississippi, and the rules of the United States Court of Appeals for the Fifth Circuit. Rules are received from the courts and edited only for stylistic consistency. For further information, see the Preface to the Mississippi Court Rules volume.

CROSS REFERENCES

Cross references refer you to notes under other Code sections, that may affect a law or place it in context. Cross references also are used under repealed provisions to refer you to an existing law on a similar subject. Cross references do not cite all related statutes, however, since these can be identified by using the General Index.

See also *Comparable Legislation from other States* and *Federal Aspects.*

EDITOR'S NOTES

Editor's notes are notes prepared by the Publisher that contain information about important or unusual features of a law, or special circumstances surrounding passage of the law, that are not apparent from the law's text.

See also *Effective Dates.*

EFFECTIVE DATES

Absent a specific effective date provision within an act, Mississippi laws generally take effect upon approval date, which is the date the act is signed into law by the Governor.

FEDERAL ASPECTS

Notes to federal legislation that is similar in subject matter and scope to the laws of Mississippi are referenced throughout the Code. In addition, the Code contains the United States Code Service citation for any federal law that is referred to in a Mississippi statute by its popular name or by its session law designation.

See also *Comparable Legislation from other States.*

HISTORY NOTES

Each section of the Code is followed by a brief note showing the acts of the Legislature on which it is based, including the act that originally enacted the section and any subsequent amendments.

The history note follows the section text, preceding any other annotations for the section. Information in the history note is listed in chronological order, first by Codes, then by Laws, with the most recent information listed last. If a section has been renumbered, the former number will appear in the history note.

The tables volume should also be consulted when researching the history of a statutory section, since it contains cross reference tables that provide a statutory citation for each section of the session laws and the date each act went into effect.

INDEX

The Code is completely indexed in two softcover Index volumes, which are updated and replaced annually. In addition, each volume of the Code is followed by its own index. As accurate and thorough as the Index is, your best defense against index wild goose chases is familiarity with indexing techniques. To that end, an explanatory Foreword to the Index appears in the first Index volume.

JOINT LEGISLATIVE COMMITTEE NOTES

Joint Legislative Committee notes are included in the Code to describe codification decisions made by the Mississippi Joint Legislative Committee on Compilation, Revision and Publication of Legislation. Examples of Committee actions that warrant the inclusion of a note are the integration of multiple amendments to a single Code section during the same legislative session, and the correction of typographical errors appearing in the Code.

JUDICIAL DECISIONS

Every reported case from the Supreme Court of Mississippi, the Court of Appeals of Mississippi, federal district courts for Mississippi, the federal Fifth Circuit Court of Appeals and the United States Supreme Court has been read for constructions of Mississippi law. These constructions are noted under pertinent sections of the statutes or Mississippi Constitution provisions, under the heading "Judicial Decisions." Where a decision has been reviewed by a higher court, subsequent judicial history and disposition is noted in the case note if such disposition has any bearing on the annotated material. Where two or more decisions state the same rule of law, the case citations are cumulated under one case note.

Case notes are grouped together under headings called "catchlines." The catchlines identify the basic subject matter of the case notes and assist the user in locating pertinent notes. Catchlines are numbered and arranged thematically, with "In general" first. Where there are two or more catchlines, an analysis, listing all the catchlines, precedes the annotations.

Frequently, statutes carry notes to cases that arose under earlier laws on the same subject. Case notes are retained so long as the editor believes the note will have some relevance under current law, though of course the relevance may be diminished by later changes in the law. These case notes appear under the heading "Decisions under former law."

OPINIONS OF THE ATTORNEY GENERAL

Opinions of the Attorney General for the State of Mississippi have been read for constructions of Mississippi law. Notes describing the subject matter of the opinions have been placed under relevant Code provisions under the heading "Opinions of the Attorney General."

ORGANIZATION AND NUMBERING SYSTEM

The Code is organized by titles, chapters, articles, subarticles, undesignated centered headings and sections. Analyses at the beginning of each title, chapter, article, and subarticle help you understand the internal arrangement of each Code unit (see *Analyses*).

Odd numbers are generally used for the numbering of titles, chapters and sections. Even numbers have been used for some chapters and sections so that a particular new chapter or section might be logically placed with other chapters and sections dealing with the same or similar subject matter. Similarly, the use of numbers with decimal points has been used for some sections in order that they may be inserted among other sections pertaining to the same subject.

The title, chapter, and section for each Code section is revealed by its section number. Thus, in the designation "§ 1-3-65," the first digit ("1") means the provision is in Title 1 ("Laws and Statutes"); the second ("3") indicates Chapter 3 ("Construction of Statutes"); and the last two digits ("65") mean the 65th section in that chapter ("Construction of terms generally").

Articles and subarticles are not reflected by section number designations.

Within sections, subsections and paragraphs usually are designated following this pattern: (1)(a)(i)1. or (1)(a)(i)A. A distinctive indention scheme is applied to suggest the relative value of each unit within this hierarchy.

PLACEMENT OF NOTES

Where a note pertains to a single statute section, it will of course be set out following that section. In many instances, however, a note applies equally to several statute sections or to an entire chapter or article. If the pertinent sections are scattered, or few in number, the note will be duplicated for each section. But where the note applies to all or most of the sections in a chapter or article, we prevent the space-consuming repetition of notes by placing the note at the very beginning of the chapter or article.

REPLACEMENT VOLUMES

The Code is periodically updated and streamlined by the replacement of volumes. Although a current set of the Code contains all currently applicable statutes, we encourage you to retain replaced volumes and their supplement pockets parts for historical reference.

RESEARCH AND PRACTICE REFERENCES

Citations to references in American Jurisprudence, American Jurisprudence Pleading and Practice, American Jurisprudence Proof of Facts, American Jurisprudence Trials, American Law Reports, First through Sixth Series, ALR Federal, Corpus Juris Secundum, various other treatises and practice guides, and Mississippi law journals are given under this heading, wherever the references appear to discuss the statute under which the citation appears, or a topic related to the statute. These citations are intended only to give you a starting point for your library research. The Mississippi law journals include Mississippi Law Journal and Mississippi College Law Review.

STATUTE HEADINGS

Headings or "catchlines" for Code sections and subsections are generally created and maintained by the publisher. They are mere catchwords and are not to be deemed or taken as the official title of a section or as a part of the section. Your suggestions for the improvement of particular catchlines are invited.

TABLES

The Mississippi Code of 1972 Annotated contains several tables that can assist you in your research. These are published in the Statutory Tables volume of the Code, and include the following:

- Sections of the Code of 1930 carried into the Code of 1942.
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- Allocation of Acts of Legislature, 1931 — 1972.
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- Consolidated Tables of amendments and repeals of 1942 Code sections.
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83-1-51. Power of commissioner to enjoin unauthorized activity in violation of any insurance law.

§ 83-1-1. Department of insurance created.

There is hereby continued a separate and distinct department of insurance, which shall be charged with the execution of all laws (except as otherwise specifically provided by statute) now in force, or which may hereafter be enacted, relative to all insurance and all insurance companies, corporations, associations, or orders.

HISTORY: Codes, 1871, § 2442; 1880, § 1073; 1892, § 2322; 1906, § 2550; Hemingway's 1917, § 5014; 1930, § 5114; 1942, § 5616; reenacted without change, Laws, 1982, ch. 366, § 1; reenacted without change, Laws, 1990, ch. 559, § 1; reenacted without change, Laws, 1996, ch. 313, § 1, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Insurance Integrity Enforcement Bureau within Attorney General's Office, see § 7-5-301 et seq.

Requirement that State Department of Insurance assist Workers' Compensation Commission in preparing report on alternative systems of workers' compensation, see § 71-3-117.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

JUDICIAL DECISIONS

1. In general.

Code 1942, chapter on insurance, §§ 5616-5834, regulating insurance companies and prescribing the duties of the commissioner of insurance in regard to the examination thereof, does not abrogate or repeal the common-law right of a stockholder in a domestic insurance corporation to inspect the books and records of the corporation. Sanders v. Neely, 197 Miss. 66, 19 So. 2d 424, 1944 Miss. LEXIS 276 (Miss. 1944).

RESEARCH REFERENCES

ALR.

Insured's ratification, after loss, of policy procured without his authority, knowledge, or consent. 52 A.L.R.3d 235.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 62 et seq.

Practice References.

Business Insurance Law and Practice Guide, (Matthew Bender).

Business Law Monographs, Volume IN1 —Business Uses of Life Insurance (Matthew Bender Elite Products).

Business Law Monographs, Volume IN2 —Casualty and Liability Insurance (Matthew Bender elite Products).

Insuring Real Property (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-1-3. Commissioner of Insurance.

The chief officer of the department shall be denominated the Commissioner of Insurance, who shall be elected at the general election as other state officers, and who shall possess the same qualifications as required for the Secretary of State. His term of office shall be four (4) years, as that of other state officials. No person shall be Commissioner of Insurance who is in any way connected with the management or control of any company, corporation, association, or order affected by this title, and his term of office shall immediately cease if at any time he shall become so interested. Before entering on the discharge of his duties, the commissioner shall take the oath of office required of state officers and give a corporate bond in favor of the state in the penal sum of Twenty-five Thousand Dollars ($25,000.00) in some company or companies duly authorized to transact business in this state, to be approved by the Governor and conditioned for the faithful performance of the duties of said office during his term, which bond and oath of office shall be filed with the Secretary of State.

HISTORY: Codes, 1906, § 2551; Hemingway's 1917, § 5015; 1930, § 5115; 1942, § 5617; reenacted without change, Laws, 1982, ch. 375, § 1; reenacted, Laws, 1990, ch. 559, § 2; reenacted without change, Laws, 1996, ch. 313, § 2, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Constitutional provision as to qualifications of secretary of state, see MS Const Art. 5, § 133.

Constitutional provision as to oath of office, see MS Const Art. 14, § 268.

Provision that a Commissioner of Insurance shall be elected in 1987 and every four years thereafter, see § 23-15-193.

Nominations for state, district, county, and county district offices which are elective, see § 23-15-291 et seq.

Guaranty or surety bonds of state officials generally, see § 25-1-13.

Salaries of state officers, see § 25-3-31.

Co-operation with state department of education in study of hazard insurance on school buildings and facilities, see § 37-3-7.

Commissioner of Insurance as State Fire Marshall, see § 45-11-1.

Duties of commissioner of insurance regarding tender offers involving domestic insurance corporations, see § 75-72-105.

Registration and examination of companies writing casualty insurance, ordinary life insurance or health and accident insurance, see §§ 83-6-1 et seq.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

Mississippi Insurance Commissioner's involvement in execution of Mississippi Rural Risk Underwriting Association Law, see §§ 83-38-1 et seq.

Commissioner's responsibility with respect to nonprofit medical liability insurance corporations, see §§ 83-47-1 et seq.

Duties of commissioner with respect to legal expense insurance, see §§ 83-49-1 et seq.

JUDICIAL DECISIONS

1. In general.

Duty and responsibility of the commissioner of insurance is prescribed primarily for the protection of the policyholders and the public, and the sections relating thereto were not intended to deal with the relation existing between the insurance corporation and its stockholders, or to require the commissioner to concern himself with the internal affairs and details of operation or management. Sanders v. Neely, 197 Miss. 66, 19 So. 2d 424, 1944 Miss. LEXIS 276 (Miss. 1944).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 67.

§ 83-1-4. Rules and regulations relative to certain general liability insurance policies.

The Commissioner of Insurance is hereby authorized and directed to promulgate rules and regulations necessary to establish a plan for the availability of commercial liability insurance contracts of owners', landowners' and tenants' liability policies and manufacturers' and contractors' liability policies, covering bodily injury and property damage.

The commissioner shall report on such plan to the 1987 Regular Session of the Legislature.

HISTORY: Laws, 1986, ch. 414, eff from and after passage (approved March 28, 1986).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 23-65, 667-714.

CJS.
44 C.J.S., Insurance §§ 76-143.
45 C.J.S., Insurance §§ 894-900, 1190-1209, 1337-1354, 1493-1516.

Practice References.
Business Law Monographs, Volume IN2—Casualty and Liability Insurance (Matthew Bender).

§ 83-1-5. Compensation and employees.

The commissioner shall receive a compensation to be fixed by law. He is hereby authorized to employ a clerk and stenographer and an actuary at a salary to be fixed by law; and in addition shall be allowed a sufficient sum for traveling expenses and for extra clerical help. To assist the commissioner in efficiently performing the official duties imposed upon him by law, he may employ suitable and competent persons who possess the professional skill and/or expert knowledge needed to fulfill these duties. The State Personnel Board, based upon its findings of fact, shall exempt these persons from the provisions of Section 25-3-39 when the acquisition of such professional services is precluded based on the prevailing wage in the relevant labor market, provided such compensation shall not, directly or indirectly, be in excess of the salary authorized to be paid to the deputy commissioner.

HISTORY: Codes, 1906, § 2553; Hemingway's 1917, § 5017; 1930, § 5116; 1942, § 5618; Laws, 1926, ch. 345; reenacted without change, Laws, 1982, ch. 375, § 2; reenacted without change, Laws, 1990, ch. 559, § 3; reenacted without change, Laws, 1996, ch. 313, § 3; Laws, 2012, ch. 546, § 42; Laws, 2014, ch. 396, § 1, eff from and after passage (approved Mar. 17, 2014).

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Compensation of insurance commissioner, see § 25-3-31.
Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

§ 83-1-6. Repealed.

Repealed by Laws of 1990, ch 559, § 4, eff from and after July 1, 1990.
§ 83–1–6. [En Laws, 1982, ch. 375, § 3]

Editor's Notes — Former section 83-1-6 provided for the repeal of sections 83-1-3 and 83-1-5.

§ 83-1-7. Deputy.

The commissioner shall have authority to appoint, with the consent of the Governor, a deputy commissioner, who shall have power, during his absence or inability to act from any cause, to perform any and all of the duties of the commissioner. Said deputy shall be commissioned by the Governor and shall be subject to the same requirements, restrictions, and qualifications as the commissioner, excepting that the bond of the deputy shall be in the penal sum of Ten Thousand Dollars ($10,000.00), conditioned and approved in the same manner as the bond of the commissioner.

HISTORY: Codes, 1906, § 2552; Hemingway's 1917, § 5016; 1930, § 5117; 1942, § 5619; reenacted without change, Laws, 1982, ch. 366, § 2; reenacted, Laws, 1990, ch. 559, § 5; reenacted without change, Laws, 1996, ch. 313, § 4, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Compensation of deputy commissioner, see § 25-3-39.1.

Appointment of department subordinates, see § 25-3-47.

Qualifications of commissioner, see § 83-1-3.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

§ 83-1-9. Offices.

Suitable offices in the Statehouse for conducting the business of said department shall be provided by the Governor, and the superintendent or keeper of the Statehouse shall, from time to time, furnish the necessary furniture, seal and stationery, fuel, lights, and other requirements, and properly care for said offices. The expense thereof shall be defrayed in the same manner as like expenses of other departments of the state government.

HISTORY: Codes, 1906, § 2557; Hemingway's 1917, § 5021; 1930, § 5118; 1942, § 5620; reenacted without change, Laws, 1982, ch. 366, § 3; reenacted, Laws, 1990, ch. 559, § 6; reenacted without change, Laws, 1996, ch. 313, § 5, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

§ 83-1-11. Seal.

The Department of Insurance shall have a seal, around the margin of which shall appear the words "Commissioner of Insurance, Mississippi," with the image of an eagle in the center and thirteen (13) stars over the head of the eagle. Each certificate and other official paper executed by the commissioner under authority of law and sealed with the seal of the department shall be received as evidence in all courts, investigations, and proceedings authorized by law, and may be recorded in the same manner and with like effect as a deed. All copies of papers certified by him and authenticated by said seal shall be accepted in all matters equally and in like manner as the original.

HISTORY: Codes, 1906, § 2555; Hemingway's 1917, § 5019; 1930, § 5119; 1942, § 5621; reenacted without change, Laws, 1982, ch. 366, § 4; reenacted, Laws, 1990, ch. 559, § 7; reenacted without change, Laws, 1996, ch. 313, § 6, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

§ 83-1-13. Monthly report; payment of taxes to state treasurer.

The commissioner shall furnish to the Auditor on or before the tenth day of each month a statement, in detail, of the taxes and licenses received by him under this title during the previous month, and shall pay to the Treasurer the amount in full of such taxes and licenses. The State Tax Commission shall make payment to the State Treasurer of taxes collected by it under this title in the manner provided by Section 7-9-21.

HISTORY: Codes, 1906, § 2628; Hemingway's 1917, § 5094; 1930, § 5120; 1942, § 5622; Laws, 1982, ch. 351, § 9; reenacted without change, Laws, 1982, ch. 366, § 5; Laws, 1984, ch. 462, § 3; reenacted, Laws, 1990, ch. 559, § 8; reenacted without change, Laws, 1996, ch. 313, § 7, eff from and after June 30, 1996.

Editor's Notes — Section 7-7-2, as added by Laws of 1984, Chapter 488, § 90, and amended by Laws of 1985, Chapter 455, § 14 and Laws of 1986, Chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor," and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws of 1989, Chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws of 1989, ch. 544, § 17, effective July 1, 1989, and codified as § 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration."

Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Section 27-3-4 provides that the terms "'Mississippi State Tax Commission,' 'State Tax Commission,' 'Tax Commission' and 'commission' appearing in the laws of this state in connection with the performance of the duties and functions by the Mississippi State Tax Commission, the State Tax Commission or Tax Commission shall mean the Department of Revenue."

Cross References — Executive Director of the Department of Finance and Administration generally, see § 7-7-1 et seq.

Annual reports to governor, see § 83-1-15.

Suit to recover reasonable expenses of examination of insurance company, see § 83-5-81.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

JUDICIAL DECISIONS

1. In general.

State's claim against insurance commissioner for license taxes held an account. Miller v. Henry, 139 Miss. 651, 103 So. 203, 1925 Miss. LEXIS 108 (Miss. 1925).

Insurance commissioner liable for interest only on taxes collected from time settlements were due therefor. Miller v. Henry, 139 Miss. 651, 103 So. 203, 1925 Miss. LEXIS 108 (Miss. 1925).

§ 83-1-15. Annual report to governor.

The commissioner shall, on or before the first day of May, annually, make a report to the governor, which shall show all of his official acts; the condition of all insurance companies within the meaning of this title, doing business in this state, accompanied by a condensation of their reports to him arranged in proper form for printing; the licenses issued by him, and the taxes received from all sources and paid by him to the treasurer; and such changes in the laws affecting his department, as in his judgment should be made. The governor shall transmit this report to the legislature. The commissioner shall see that all laws relating to matters under his supervision are faithfully executed. He shall supply each insurance company doing business in this state with all necessary printed forms.

HISTORY: Codes, 1857, ch. 35, art. 59; 1871, § 2444; 1880, § 1075; 1892, § 2325; 1906, § 2558; Hemingway's 1917, § 5022; 1930, § 5121; 1942, § 5623; reenacted without change, Laws, 1982, ch. 366, § 6; reenacted without change, Laws, 1990, ch. 559, § 9; reenacted without change, Laws, 1996, ch. 313, § 8, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

JUDICIAL DECISIONS

1. In general.

The power of the insurance commissioner to approve or disapprove policy provisions is a quasi-judicial power to be exercised within his sound discretion, subject to review by the courts. White v. National Old Line Ins. Co., 203 Miss. 752, 34 So. 2d 234, 1948 Miss. LEXIS 319 (Miss. 1948).

§ 83-1-17. Laws enforced by suit.

Compliance with the provisions of this title as to deposits, obligations, prohibitions, and the payment of taxes, fees, and penalties by and upon foreign insurance companies or other insurers may be enforced by the commissioner by suit in the name of the state.

HISTORY: Codes, 1906, § 2650; Hemingway's 1917, § 5116; 1930, § 5122; 1942, § 5624; reenacted without change, Laws, 1982, ch. 366, § 7; reenacted without change, Laws, 1990, ch. 559, § 10; reenacted without change, Laws, 1996, ch. 313, § 9, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

Injunctive relief for violations relating to legal expense insurance plans and appointment of receivers, see § 83-49-31.

JUDICIAL DECISIONS

1. In general.

There is no prohibition against the insurance commissioner joining with the attorney general in a bill of complaint for the enforcement of the insurance statutes. Gandy v. Reserve Life Ins. Co., 279 So. 2d 648, 1973 Miss. LEXIS 1489 (Miss. 1973).

RESEARCH REFERENCES

Practice References.

Business Law Monographs, Volume IN1—Business Uses of Life Insurance (Matthew Bender Elite Products).

Business Law Monographs, Volume IN2—Casualty and Liability Insurance (Matthew Bender elite Products).

Insuring Real Property (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-1-19. Group insurance for state employees.

The state insurance commissioner is hereby authorized, empowered and directed, in his discretion, to promulgate such regulations as may properly apply to the writing of group insurance on state officials and employees. Such insurance shall be optional with any one or all of said state officials or employees.

HISTORY: Codes, 1930, § 5123; 1942, § 5625; Laws, 1930, ch. 53; reenacted without change, Laws, 1982, ch. 366, § 8; reenacted without change, Laws, 1990, ch. 559, § 11; reenacted without change, Laws, 1996, ch. 313, § 10, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Group insurance for public employees generally, see §§ 25-15-101, 25-15-103.

Use of red lights on vehicles used by firemen of volunteer fire departments which receive funds under this section, see §§ 63-7-19 and 63-7-20.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

RESEARCH REFERENCES

ALR.

Group insurance: Waiver or estoppel on basis of statements in promotional or explanatory literature issued to insureds. 36 A.L.R.3d 541.

§ 83-1-21. Reports on file as public record.

The commissioner shall keep in his office for public inspection all reports received by him, a record of all his proceedings, including a concise statement of the result of official examinations, an exhibit of the financial condition and methods of all insurers under his supervision, as disclosed by their statements or by official examination, and such other information with regard to them as he may deem it proper to preserve.

Such reports or records which are no longer useful or necessary may be disposed of in accordance with approved records control schedules. No records, however, may be destroyed without the approval of the Director of the Department of Archives and History.

HISTORY: Codes, 1906, § 2560; Hemingway's 1917, § 5025; 1930, § 5124; 1942, § 5626; Laws, 1946, ch. 361, § 1; Laws, 1981, ch. 501, § 26; reenacted, Laws, 1982, ch. 366, § 9; reenacted, Laws, 1990, ch. 559, § 12; reenacted without change, Laws, 1996, ch. 313, § 11, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws, 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Requirement that consent of director of department of archives and history be obtained prior to destruction of public records, see §§ 25-59-21, 25-59-31.

Archives and Records Management Law, generally, see §§ 25-59-21 et seq.

Confidentiality and disclosure of public records, generally, see § 25-59-27.

Annual statements by insurance companies, see § 83-5-55.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

§ 83-1-23. Examination before granting authority.

Before granting a certificate of authority to any insurance company organized under the laws of another state or government, the commissioner shall be satisfied that it is qualified to transact business under the laws of the state in which it has its principal office, and also as to its financial ability and condition.

HISTORY: Codes, 1880, § 1085; 1892, § 2327; 1906, § 2564; Hemingway's 1917, § 5029; 1930, § 5125; 1942, § 5627; reenacted without change, Laws, 1982, ch. 366, § 10; reenacted without change, Laws, 1990, ch. 559, § 13; reenacted without change, Laws, 1996, ch. 313, § 12, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Examination of foreign insurance companies, see § 83-1-27.

Registration and examination of companies writing casualty insurance, ordinary life insurance or health and accident insurance, see §§ 83-6-1 et seq.

Statement to be filed by foreign insurance company seeking to do business within the state, see § 83-21-1.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

Examination of burial associations by insurance commissioner, see § 83-37-25.

JUDICIAL DECISIONS

1. In general.

Where a certificate of authority to transact insurance was issued to a foreign insurance company in accordance with § 83-1-23, and the certificate had been neither revoked nor suspended, such company is still authorized to transact business in Mississippi and the claim against the company arising prior to its insolvency is covered. Mississippi Ins. Guaranty Asso. v. Gandy, 289 So. 2d 677, 1973 Miss. LEXIS 1210 (Miss. 1973).

Act of insurance commissioner issuing license to company is judicial and cannot be reviewed by mandamus. Cole v. State, 91 Miss. 628, 45 So. 11, 1907 Miss. LEXIS 168 (Miss. 1907).

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of statute establishing compensation for claims not paid because of insurer's insolvency. 30 A.L.R.4th 1110.

§ 83-1-25. Repealed.

Repealed by Laws of 1997, ch. 410, § 23, eff from and after July 1, 1997.

§ 83-1-25. [Codes, 1906, § 2565; Hemingway's 1917, § 5030; 1930, § 5126; 1942, § 5628; Laws, 1944, ch. 322; Laws, 1946, ch. 355, § 1; Laws, 1958, ch. 432; Laws, 1966, ch. 520, § 1; Laws, 1972, ch. 325, § 1; Laws, 1982, ch. 351, § 11; reenacted, Laws, 1982, ch. 366, § 11; Laws, 1984, ch. 462, § 4; reenacted, Laws, 1990, ch. 559, § 14; repealed, Laws, 1992, ch. 319, § 10; reenacted, Laws, 1996, ch. 313, § 13].

Editor's Notes — Former § 83-1-25 authorized the Commissioner of Insurance to conduct financial examinations of domestic insurance companies.

§ 83-1-27. Examination of foreign concerns; funding of agency expenses; deposit of monies into State General Fund.

Whenever the Commissioner of Insurance deems it prudent for the protection of the policyholders in this state, he shall in like manner visit and examine, or cause to be visited and examined by some competent person or persons he may appoint for that purpose, any foreign insurance company applying for admission or already admitted to do business by agencies in this state, and such companies shall pay the proper charges incurred in such examination, including the expense of the commissioner or his deputy and the expenses and compensation of his assistants employed therein. For the purpose aforesaid, the commissioner or his deputy or persons making examination shall have free access to all the books and papers of the insurance company that relate to its business and to the books and papers kept by any of its agents, and may summon and qualify as witnesses, under oath, and examine the directors, officers, agents and trustees of any such company, and any other persons in relation to its affairs, transactions and conditions. Such examination shall be made by the commissioner, or by his accredited representatives, and such companies shall pay the proper charges incurred in such examination, including the expense of the commissioner or financial examiners, actuaries, market conduct examiners, accountants, attorneys or other professional service organizations necessary to administer this section. The Department of Insurance may contract with professional service organizations to examine all companies under its jurisdiction, and the professional service organization may directly bill the company under examination. The commissioner shall monitor the charges for these professional services and verify that all costs are reasonable. If a company fails to pay these fees within thirty (30) days of billing, the commissioner, after notice and a hearing, is authorized to impose an administrative fine not to exceed One Thousand Dollars ($1,000.00) per day to be deposited into the special fund in the State Treasury designated as the "Insurance Department Fund." The compensation and expense of the commissioner or such examiner for the commissioner shall not exceed that approved by the National Association of Insurance Commissioners for all financial and market conduct examiners on such examinations, itemized account of such charges being rendered to and approved by the Commissioner of Insurance.

The results of audits performed hereunder by the Commissioner of Insurance may be furnished to the State Tax Commission. Nothing herein shall be construed to prohibit the State Tax Commission from performing such additional audits or verifications as it may deem necessary to insure the proper payment of taxes.

From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1906, § 2566; Hemingway's 1917, § 5031; 1930, § 5127; 1942, § 5629; Laws, 1958, ch. 433; Laws, 1972, ch. 324, § 1; Laws, 1982, ch. 351, § 12, reenacted, Laws, ch. 366, § 12; Laws, 1984, ch. 462, § 5; reenacted, Laws, 1990, ch. 559, § 15; reenacted without change, Laws, 1996, ch. 313, § 14; Laws, 1997, ch. 410, § 1; Laws, 2016, ch. 459, § 18, eff from and after July 1, 2016.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws, 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Section 27-3-4 provides that the terms "'Mississippi State Tax Commission,' 'State Tax Commission,' 'Tax Commission' and 'commission' appearing in the laws of this state in connection with the performance of the duties and functions by the Mississippi State Tax Commission, the State Tax Commission or Tax Commission shall mean the Department of Revenue."

Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agency by appropriation of Legislature from General Fund, see § 27-104-205.

Examination of foreign insurance company before granting authority to do business, see § 83-1-23.

Examined party's payment of costs related to review for compliance with §§ 83-2-1 et seq., effective from and after January 1, 1988, see § 83-2-25.

Fees for commissioner, see § 83-5-73.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 85.

CJS.

44 C.J.S., Insurance §§ 129, 130.

§ 83-1-29. Suspension or revocation of certificate of authority.

Whenever it shall appear to the commissioner, upon examination or other evidence, that a foreign insurance company is in an unsound condition, or upon notification by the State Tax Commission that the company is delinquent in the payment of taxes due the state, or that it has failed to comply with the law, or that it, its officers, or agents, refused to submit to examination or to perform any legal obligation in relation thereto, he shall revoke or suspend all certificates of authority granted to it or its agents, and shall cause notification thereof to be published in one or more newspapers published in this state. No new business shall thereafter be done by it or its agents in this state while such default or disability continues, nor until its authority to do business is restored by the commissioner. If, upon examination, he is of the opinion that any domestic insurance company is insolvent, or has exceeded its powers, or has failed to comply with any provision of law applicable to it, or that its condition is such as to render its further proceeding hazardous to the public or its policyholders, or upon notification by the State Tax Commission that the company is delinquent in the payment of taxes due the state, he shall suspend its license. If he deems it necessary, he shall apply to a judge of the chancery court to issue an injunction restraining it, in part or in whole from further proceeding with its business. Such judge may, in his discretion, issue the injunction forthwith or upon notice and hearing thereon and, after a full hearing of the matter, may dissolve or modify such injunction or make it permanent, may make all orders and decrees needful in the premises, and may appoint agents or receivers to take possession of the property or effects of the company and to settle its affairs, subject to such rules and orders as the court may, from time to time, prescribe according to the course of proceedings in equity.

HISTORY: Codes, 1906, § 2567; Hemingway's 1917, § 5032; 1930, § 5128; 1942, § 5630; Laws, 1982, ch. 351, § 10; reenacted without change, Laws, 1982, ch. 366, § 13; Laws, 1984, ch. 462, § 6; reenacted, Laws, 1990, ch. 559, § 16; reenacted without change, Laws, 1996, ch. 313, § 15, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws, 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Section 27-3-4 provides that the terms "'Mississippi State Tax Commission,' 'State Tax Commission,' 'Tax Commission' and 'commission' appearing in the laws of this state in connection with the performance of the duties and functions by the Mississippi State Tax Commission, the State Tax Commission or Tax Commission shall mean the Department of Revenue."

Cross References — Revocation of licenses, see § 83-5-17.

Revocation of license for refusal to comply with provisions of insurance law, see § 83-5-83.

Application of this section to suspension, revocation or refusal of license for failure to submit to examination by commissioner, see § 83-5-207.

Additional authority to suspend, revoke or to refuse to renew license or certificate of authority of insurer, see § 83-6-39.

Impairment of capital, see § 83-19-57.

Appointment of receiver for insolvent company, see § 83-23-1.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

JUDICIAL DECISIONS

1. In general.

When a contractor sued insurers and their agent for negligently issuing a bid bond without authority, due to expiration of the agent's certificate for failure to pay a renewal fee, summary judgment erred because the agent was unauthorized to issue the bond, which had to be valid on the date issued but was null and void, and a later payment of the fee and reinstatement of the agent did not retroactively validate the bond, so fact questions existed as to the negligent issuance of the bond contrary to a duty to the contractor. King Metal Bldgs., Inc. v. Renasant Ins., Inc., 159 So. 3d 567, 2014 Miss. App. LEXIS 377 (Miss. Ct. App. 2014), cert. denied, 158 So. 3d 1153, 2015 Miss. LEXIS 142 (Miss. 2015).

Since under statutes conferring authority on insurance commissioner to act make the interest of the policyholders paramount, immediate action is justified when the policyholder's interest is endangered, and ex parte orders suspending an insurance company's certificate, temporary restraining orders, and temporary appointments ordered without notice are acceptable. State Sec. Life Ins. Co. v. State, 498 So. 2d 825, 1986 Miss. LEXIS 2840 (Miss. 1986).

Where the insurance commission is of the opinion that an insurance company's insolvent condition could endanger its policyholders, he may suspend the company's license and take other appropriate measures. State Sec. Life Ins. Co. v. State, 498 So. 2d 825, 1986 Miss. LEXIS 2840 (Miss. 1986).

On complaint filed by the insurance commission, following examination of an insurance company, alleging the insurance company was insolvent and its condition such as to render further business hazardous to the public and to its policyholders, chancellor did not abuse his discretion in granting a temporary restraining order prohibiting the insurance company from further business and appointing the insurance commissioner as its temporary receiver, and in compelling the insurance company and its affiliates to turn over to the insurance commissioner all documents and other records which were requested by the insurance commissioner in writing for the purpose of determining the financial condition and the legality of the conduct of the insurance company and its affiliates. State Sec. Life Ins. Co. v. State, 498 So. 2d 825, 1986 Miss. LEXIS 2840 (Miss. 1986).

Section 83-1-29 provides the steps required to be taken to revoke or suspend insurance company's certificate of authority. Mississippi Ins. Guaranty Asso. v. Gandy, 289 So. 2d 677, 1973 Miss. LEXIS 1210 (Miss. 1973).

Duty and responsibility of the commissioner of insurance is prescribed primarily for the protection of the policyholders and the public, and the statutory provisions relating thereto were not intended to deal with the relation existing between the insurance corporation and its stockholders, or to require the commissioner to concern himself with the internal affairs and details of operation or management. Sanders v. Neely, 197 Miss. 66, 19 So. 2d 424, 1944 Miss. LEXIS 276 (Miss. 1944).

Insurance policies providing for monthly income to assured for life were annuity policies and not life insurance policies, and therefore were not void and subject to cancelation because of company's failure to comply with provisions that a policy of life insurance shall not be issued or delivered in this state until the form has been approved and filed by the insurance commissioner, notwithstanding that they also provided for payment to another of the balance, if any, of the single premium remaining after assured's death. Hamilton v. Penn Mut. Life Ins. Co., 196 Miss. 345, 17 So. 2d 278, 1944 Miss. LEXIS 200 (Miss. 1944).

Annuity policies, though not life insurance policies, are such as a life insurance company is authorized to issue and therefore are subject to the provisions of the statute regulating the business of life insurance companies, and not to the requirement of the blue sky law. Hamilton v. Penn Mut. Life Ins. Co., 196 Miss. 345, 17 So. 2d 278, 1944 Miss. LEXIS 200 (Miss. 1944).

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of statute establishing compensation for claims not paid because of insurer's insolvency. 30 A.L.R.4th 1110.

Am. Jur.

43 Am. Jur. 2d, Insurance § 67.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance §§ 135, 136.

§ 83-1-31. Audit of books to determine tax liability.

When, in the judgment of the Insurance Commissioner, or upon request by the State Tax Commission, an audit, examination, or inspection of the books, records, invoices, papers, memoranda, or other data appears to be required or necessary to determine the assessment of a tax, or to establish a tax liability, or to verify a payment of a tax, under the tax laws of this state, of a taxpayer doing business both within and without the state and maintaining his principal place of business outside the state, such audit, or examination, or inspection may be made at the principal place of business outside the state to the same extent and same effect as audits, examinations, or inspections are made of books, records, invoices, papers, memoranda, or other data located in this state.

The Insurance Commissioner, who is directly charged with the duty of auditing the records necessary for use by the State Tax Commission in assessing and collecting taxes under laws which require a taxpayer to keep adequate books, records, papers, invoices, memoranda, or other data at a place in this state, reflecting his liability for any tax due the state, and which taxpayer conducts his business both within and without Mississippi and maintains his principal place of business outside this state, at which his books, records, etc., are located, may elect to audit, examine, or inspect all books, records, papers, invoices, memoranda, or other data reflecting upon the Mississippi tax assessment and tax liability at the principal place of business of the taxpayer, rather than require the taxpayer to transport all of his books, records, papers, invoices, memoranda, and other data to some place in this state.

HISTORY: Codes, 1942, § 9218; Laws, 1942, ch. 126; Laws, 1982, ch. 351, § 13; reenacted without change, Laws, 1982, ch. 366, § 14; Laws, 1984, ch. 462, § 7; reenacted, Laws, 1990, ch. 559, § 17; reenacted without change, Laws, 1996, ch. 313, § 16, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Section 27-3-4 provides that the terms "'Mississippi State Tax Commission,' 'State Tax Commission,' 'Tax Commission' and 'commission' appearing in the laws of this state in connection with the performance of the duties and functions by the Mississippi State Tax Commission, the State Tax Commission or Tax Commission shall mean the Department of Revenue."

Cross References — Liability for cost of audit, see § 83-1-33.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

§ 83-1-33. Taxpayer liable for cost of audit.

When the insurance commissioner shall elect to audit, examine, or inspect the books, records, papers, invoices, memoranda, or other data of a taxpayer at his principal place of business outside this state, he shall designate, in writing, his agent or agents, employee or employees, to make the audit, examination, or inspection at the principal place of business of the taxpayer, and shall state the kind of tax for which the audit, examination, or inspection is thereby made.

In regard to inspection made by the commissioner of insurance the cost thereof, to include only the actual expenses involved to be determined after audit, examination, or inspection has been made, shall be paid by the taxpayer. The commissioner shall first approve the account or cost of such examination and determine to his satisfaction that it is reasonable, and that there are charged only the direct expenses involved in making the audit, examination, or inspection. He shall then pay, from the support funds authorized by the legislative act to be used by him in the administration of the duties of his office, to the agent or agents, employee or employees who made the audit, examination, or inspection, his, or their, itemized expense accounts. Then a detailed itemized statement of the expenses or cost of such audit, examination, or inspection shall be rendered the taxpayer. If such is done, the taxpayer shall be directed to pay the cost thereby set out as a refund into the treasury of the State of Mississippi to the credit of the support fund account of the officer who made the audit, examination, or inspection; and the treasurer's receipt shall be mailed to the taxpayer.

The charge for or cost of any audit, examination, or inspection of the books, records, papers, invoices, memoranda, or other data made by the commissioner of insurance at the principal place of business outside this state of any taxpayer, and made under the provisions of any of the tax laws shall become a liability of the taxpayer to the State of Mississippi, collectible in the same manner as is the tax imposed by the tax law under which the audit, examination, or inspection has been made.

HISTORY: Codes, 1942, § 9219; Laws, 1942, ch. 126; Laws, 1958, ch. 553; reenacted without change, Laws, 1982, ch. 366, § 15; reenacted without change, Laws, 1990, ch. 559, § 18; reenacted without change, Laws, 1996, ch. 313, § 17, eff from and after June 30, 1996.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

§ 83-1-35. Reward in case of willful destruction by fire or explosion of real or personal property within state.

The Commissioner of Insurance is hereby authorized, in his discretion, to offer a reward not to exceed Five Thousand Dollars ($5,000.00) for information leading to the apprehension, indictment and conviction of any person, persons or organization of persons responsible for the willful destruction by fire or explosion of any real or personal property located within this state.

The Commissioner of Insurance is further directed to have suitable reward notices printed and posted in conspicuous places, and to utilize such other news media or informational materials as necessary to encourage those with information to come forward.

The reward monies paid, if any, as well as the cost of printing and distribution of reward notices and other news media or informational materials, shall be paid from premium taxes under Sections 27-15-103 and 27-15-109. However, the Commissioner of Insurance shall keep a separate account of all monies disbursed under the provisions of this section and shall include the same in his annual report.

HISTORY: Codes, 1942, § 5630.5; Laws, 1958, ch. 447, §§ 1-3; Laws, 1979, ch. 316; Laws, 1982, ch. 351, § 14; reenacted, Laws, 1982, ch. 366, § 16; reenacted, Laws, 1990, ch. 559, § 19; reenacted without change, Laws, 1996, ch. 313, § 18; Laws, 2013, ch. 324, § 1, eff from and after July 1, 2013.

Editor's Notes — Laws of 1996, ch. 313, § 20, amended Laws, 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Cross References — Authority to insure school buildings, see § 37-7-303.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

§ 83-1-37. Municipal fire protection fund.

(1) The Department of Revenue shall pay for credit to a fund known as the "Municipal Fire Protection Fund," the sum of Four Million Eight Hundred Fifty Thousand Dollars ($4,850,000.00) annually out of the insurance premium tax collected annually from the taxes levied on the gross premiums on fire insurance policies written on properties in this state, under Sections 27-15-103 through 27-15-127. The State Treasurer shall credit this amount to the Municipal Fire Protection Fund. This fund shall be set aside and earmarked for payment to municipalities in this state, as hereinafter provided.

(2) Using 1990 as a base year, the Department of Revenue shall pay over annually to the State Treasurer, for credit to the "Municipal Fire Protection Fund," an amount representing one-half of ten percent (½ of 10%) of any growth after 1990 of the insurance premium tax collected annually from the taxes levied on the gross premium on fire insurance policies written on properties in this state, under Sections 27-15-103 through 27-15-127.

(3) The fund hereby created and denominated "Municipal Fire Protection Fund" shall be apportioned and paid over by the Department of Insurance to the incorporated municipalities certified as eligible to participate in the fund by the Commissioner of Insurance, and shall be distributed in the following manner annually: each municipality shall be paid Six Thousand Dollars ($6,000.00), with the remainder of the monies to be paid on a population basis, to be determined by the most recent federal census. Municipalities receiving these funds shall earmark such monies for fire protection services.

(4) The amount paid under subsections (1) and (2) of this section to a municipality shall be used and expended in accordance with the guidelines established by the Commissioner of Insurance authorized by Section 45-11-7, for the training of municipal personnel as needed for the adoption of and compliance with the minimum building codes as established and promulgated by the Mississippi Building Codes Council, for windstorm mitigation programs as approved by the Commissioner of Insurance, and for emergency medical service training and equipment as provided by municipal fire protection services. A municipality may provide reasonable remuneration to municipal volunteer firefighters in accordance with the guidelines established by the Commissioner of Insurance authorized by Section 45-11-7.

(5) Each municipality shall levy a tax of not less than one-fourth (¼) mill on all property of the municipality or appropriate the avails of not less than one-fourth (¼) mill from the municipality's general fund for fire protection purposes. Municipalities may allow such millage to be collected by the county. Each municipality shall annually provide the Commissioner of Insurance and the State Fire Coordinator on a form provided by the State Fire Coordinator a report stating whether the municipality is levied the one-fourth (¼) mill hereby required or in lieu thereof is allowing such millage to be collected by the county.

(6) The Commissioner of Insurance may promulgate rules and regulations to establish guidelines for the use of fire rebate funds.

HISTORY: Codes, 1942, § 3494.7; Laws, 1950, ch. 415, §§ 1-4; Laws, 1954, ch. 344, § 4 [¶ 4]; Laws, 1966, ch. 595, § 1; Laws, 1971, ch. 342, § 1; Laws, 1981, ch. 365, § 2; Laws, 1982, ch. 351, § 15; reenacted, Laws, 1982, ch. 366, § 17; Laws, 1984, ch. 462, § 8; Laws, 1988, ch. 584, § 8; Laws, 1990, ch. 558, § 3; reenacted and amended, Laws, 1990, ch. 559, § 20; Laws, 1994, ch. 418, § 6; Laws, 1994, ch. 577, § 2; reenacted, Laws, 1996, ch. 313, § 19; Laws, 2008, ch. 412, § 2; Laws, 2011, ch. 460, § 3, eff from and after July 1, 2011; Laws, 2022, ch. 428, § 2, eff from and after July 1, 2022.

Editor's Notes — Section 7-7-2, as added by Laws of 1984, Chapter 488, § 90, and amended by Laws of 1985, Chapter 455, § 14 and Laws of 1986, Chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor," and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws of 1989, Chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws of 1989, ch. 544, § 17, effective July 1, 1989, and codified as § 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration."

Laws of 1996, ch. 313, § 20, amended Laws of 1990, ch. 559, § 24, to remove the language providing for the repeal of the amendment by that act effective June 30, 1996.

Amendment Notes — The 2022 amendment, in the first sentence of (3), substituted "distributed in the following manner annually: each municipality shall be paid Six Thousand Dollars ($6,000.00), with the remainder of the monies to be paid on" for "distributed once each year on" and deleted "except as provided in subsection (4) of this section" from the end; deleted former (4), which provided for the annual designation of two hundred fifty thousand dollars from the Municipal Fire Protection Fund for certain training of municipal personnel; redesignated former (5) as (4), and therein, in the first sentence, added "and for emergency medical service training...fire protection services" at the end of the first sentence, and made related changes, and added the last sentence; redesignated former (6) as (5); and added (6).

Cross References — Premium taxes generally, see §§ 27-15-103 et seq.

Duties and responsibilities of the commissioner of insurance and the fire service coordinator of the division of fire services development with respect to the eligibility for, distribution of, use of, and accountability for, funds distributed pursuant to this section, see § 45-11-7.

Authorization for the board of supervisors of any county and the governing body of any municipality to contribute funds directly to any fire protection district or volunteer fire department serving the county or municipality to meet any standards established by the commissioner of insurance as provided in this section, see § 83-1-39.

Mississippi Windstorm Mitigation Coordinating Council created to develop and implement comprehensive, coordinated approach for windstorm mitigation, see § 83-1-201.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

OPINIONS OF THE ATTORNEY GENERAL

Town of Tunica may contract with private nonprofit volunteer fire organization to provide fire protection services but insurance rebate funds must be expended consistent with statutory limitations. Dulaney, March 20, 1998, A.G. Op. #98-0137.

A municipality may only purchase equipment, materials, supplies or provide funds for a fire protection district pursuant to an interlocal agreement with the fire protection district. Hatcher, October 30, 1998, A.G. Op. #98-0666.

Payments to individual firefighters for responding to fires on a per call basis are not properly classified as improvements to the fire department of the municipality for purposes of the use of municipal fire protection funds pursuant to subsection (4) of this section. Breeden, March 19, 1999, A.G. Op. #99-0115.

The governing authorities of a municipality would be operating within the constraints of this section were that body to determine that the use of fire rebate funds to purchase insurance for municipally-owned firefighting equipment or fire department property was an expenditure for fire protection purposes. The municipality would not be authorized to pay the premiums on any property not owned by the municipality. Eubanks, May 14, 2005, A.G. Op. 04-0209.

Fire insurance rebate funds may properly be used for "child finder" and "special needs" decals, as well as for the provision of internet service at the fire station, so long as the internet service is used in furtherance of municipal fire protection. McWilliams, Sept. 30, 2005, A.G. Op. 05-0432.

Money raised by the volunteer fire department may be used for any lawful purpose deemed appropriate by the governing board of the non-profit volunteer fire department. Simmons, Nov. 10, 2006, A.G. Op. 06-0560.

RESEARCH REFERENCES

CJS.

44 C.J.S., Insurance §§ 118-120.

§ 83-1-39. County volunteer fire department fund; fund for insurance rebate monies not expended for fire protection purposes.

(1) The Department of Revenue shall pay over to the State Treasurer, to be credited to a fund entitled "County Volunteer Fire Department Fund," the sum of Four Million Eight Hundred Fifty Thousand Dollars ($4,850,000.00) annually out of the insurance premium tax in addition to the amount collected by it under the provisions of Section 27-15-103 et seq. Such funds, hereinafter referred to as insurance rebate monies, are hereby earmarked for payment to the various counties of the state and shall be paid over to the counties by the Department of Insurance in the following manner: each county shall be paid Thirty Thousand Dollars ($30,000.00), with the remainder of the monies to be paid on the basis of the population of each county as it compares to the population of participating counties, not counting residents of any municipality. Such insurance rebate monies shall only be distributed to those counties which are in compliance with subsections (5) and (6) of this section.

(2) Using 1990 as a base year, the Department of Revenue shall pay to the State Treasurer, to be credited to the "County Volunteer Fire Department Fund," an amount representing one-half of ten percent (½ of 10%) of any growth after 1990 of the insurance premium tax collected annually from the taxes levied on the gross premium on fire insurance policies written on properties in this state, in addition to the amount collected by it under Section 27-15-103 et seq.

(3) Insurance rebate monies shall be expended by the board of supervisors for fire protection purposes of each county for the following categories:

(a) For training expenses, including emergency medical services training;

(b) Purchase of equipment, purchase of fire trucks, repair and refurbishing of fire trucks and firefighting equipment, for emergency medical services equipment, and capital construction anywhere in the county or pledging as security for a period of not more than ten (10) years for such purchases;

(c) Purchase of insurance on county-owned firefighting or emergency medical services equipment;

(d) Fire protection service contracts, including, but not limited to, municipalities, legal fire protection districts, and nonprofit corporations providing or coordinating fire service or emergency medical services in or out of the county;

(e) Appropriations to legal fire protection districts located in counties subject to all restrictions applicable to the use of insurance rebate monies;

(f) Training of any county personnel as needed for the adoption of and compliance with the codes established and promulgated by the Mississippi Building Codes Council or for windstorm mitigation programs as approved by the Commissioner of Insurance;

(g) Any county-owned equipment or other property, at the option of the board of supervisors, may be used by any legally created fire department;

(h) At the option of the board of supervisors, a county may provide reasonable remuneration to volunteer firefighters in accordance with the guidelines established by the Commissioner of Insurance authorized by Section 45-11-7; or

(i) For any use allowed in accordance with the guidelines as established by the Commissioner of Insurance.

(4) Insurance rebate monies not expended in a given fiscal year for fire protection purposes shall be placed in a special fund with a written plan approved by the Commissioner of Insurance for disposition and expenditure of such monies. After the contracts for fire protection services have been approved and accepted by the board of supervisors, the monies shall be released to be expended in such manner as provided by this section.

(5) No county shall receive payments pursuant to this section after July 1, 1988, unless such county:

(a) Designates a county fire service coordinator who is responsible for seeing that standard guidelines established by the Commissioner of Insurance pursuant to Section 45-11-7(9), Mississippi Code of 1972, are followed. The county fire coordinator must demonstrate that he possesses fire-related knowledge and experience;

(b) Designates one (1) member of the sheriff's department to be the county fire investigator and, from and after July 1, 2008, requires the designated member of the sheriff's department to attend the State Fire Academy to be trained in arson investigation; however, in the event of a loss of the county fire investigator due to illness, death, resignation, discharge or other legitimate cause, notice shall be immediately given to the Commissioner of Insurance and the county may continue to receive payments on an interim basis for a period not to exceed one (1) year;

(c) Adheres to the standard guidelines established by the Commissioner of Insurance pursuant to Section 45-11-7(9); and

(d) Counties shall levy a tax of not less than one-fourth (¼) mill on all property of the county or appropriate avails of not less than one-fourth (¼) mill from the county's general fund for fire protection purposes. Municipalities making a written declaration to the county that they fund and provide their own fire services shall be exempted from this levy. This levy shall be used for fire protection purposes which include, but are not limited to, contracting with any provider of fire protection services.

(6)(a) No funds shall be paid by the county to any provider of fire protection services except in accordance with a written contract entered into in accordance with guidelines established by the Commissioner of Insurance and properly approved by the board of supervisors and Commissioner of Insurance. No county shall distribute funds to any fire service provider which has not met the reporting requirements required by the Commissioner of Insurance. At such time that a fire protection services provider, particularly a county volunteer fire department, a municipality or a fire protection district, has fulfilled the obligations of the written contract and has met the reporting requirements provided for in this subsection and the board of supervisors has received the insurance rebate monies, the board of supervisors shall disburse the appropriate amount to the fire protection services provider within a reasonable time, not to exceed six (6) weeks, from the time such requirements are met. Insurance rebate monies used for the purposes of contracting shall be expended by the fire service provider for capital construction, training expenses, purchase of firefighting equipment, including payments on any loans made for the purpose of purchasing firefighting equipment, purchase of insurance for any fire equipment owned or operated by the provider, and for training and equipment of emergency medical services as provided by fire protection services.

(b) If the Commissioner of Insurance believes that a county is using the funds in a manner not consistent with subsections (5) and (6) of this section, the commissioner shall request the State Auditor to conduct an investigation pursuant to Section 7-7-211(e).

(7) The board of supervisors of any county may contribute funds directly to any provider of fire protection services serving such county. Such contributions must be used for fire protection purposes as may be reasonably established by the Commissioner of Insurance.

(8) Any municipal, county or local water association or other utility district supplying water may, upon adoption of a resolution authorizing such action, contribute free of charge to a volunteer fire department or fire protection district serving such local government, political subdivision or utility district such water as is necessary for firefighting or training activities of such volunteer fire department or fire protection district.

(9) The board of supervisors of any county may, in its discretion, grade, gravel, shell and/or maintain real property of a county volunteer fire department, including roads or driveways thereof, as necessary for the effective and safe operation of such county volunteer fire department. Any action taken by the board of supervisors under the authority of this subsection shall be spread upon the minutes of the board of supervisors when the work is authorized.

(10) For the purpose of this section, "fire protection district" means a district organized under Section 19-5-151 et seq., or pursuant to any other code section or by any local and private act authorizing the establishment of a fire protection district, unless the context clearly requires otherwise.

(11) The Commissioner of Insurance may promulgate rules and regulations to establish guidelines for the use of fire rebate funds.

HISTORY: Laws, 1973, ch. 496, § 1; Laws, 1974, ch. 408; Laws, 1975, ch. 472; Laws, 1976, ch. 442; Laws, 1982, ch. 351, § 16; reenacted, Laws, 1982, ch. 366, § 18; Laws, 1984, ch. 339; Laws, 1984, ch. 462, § 9; Laws, 1988, ch. 584, § 9; Laws, 1988, ch. 596, § 1; Laws, 1989, ch. 329, § 2; Laws, 1989, ch. 538, § 1; reenacted, Laws, 1990, ch. 559, § 21; Laws, 1991, ch. 536, § 1; Laws, 1994, ch. 418, § 7; Laws, 1994, ch. 577, § 3; Laws, 2004, ch. 522, § 1; Laws, 2007, ch. 485, § 1; Laws, 2008, ch. 412, § 3; Laws, 2011, ch. 460, § 4, eff from and after July 1, 2011; Laws, 2022, ch. 428, § 3, eff from and after July 1, 2022.

Editor's Notes — Section 7-7-2, as added by Laws of 1984, Chapter 488, § 90, and amended by Laws, 1985, Chapter 455, § 14 and Laws of 1986, Chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor," and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws of 1989, Chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws of 1989, ch. 544, § 17, effective July 1, 1989, and codified as § 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration."

Laws of 1990, ch. 559, § 24, provided for the repeal of this section effective June 30, 1996. Subsequently, Laws of 1993, ch. 363, § 1, amended Laws of 1990, ch. 559, § 24, so as to remove the repeal provision with respect to this section.

Amendment Notes — The 2022 amendment, in (1), inserted "in the following manner:...remainder of the monies to be paid" and deleted the former last sentence, which read: "Of these monies, Two Hundred Fifty Thousand Dollars ($250,000.00) shall be designated for the purposes prescribed in subsection (3)(f) of this section"; in (3), added "including emergency medical services training" in (a), "for emergency medical services equipment" in (b), and "or emergency medical services" in (c) and (d), deleted the former last two sentences of (f), which provided that monies designated under (f) that were not expended annually would be returned to the County Volunteer Fire Protection Fund, and added (h) and (i); in (6)(a), added "and for training...fire protection services" at the end and made a related change; and added (11).

Cross References — Rural fire truck acquisition assistance program, see §§ 17-23-1 et seq.

Authority of the board of supervisors of a county to grade, gravel, shell, and maintain real property, including roads or driveways thereof, owned by a municipal or county fire protection district, see § 19-3-73.

Authorization of county appropriations to volunteer fire departments meeting requirements of subsection (6) of this section, see § 19-5-95.

Duties and responsibilities of the commissioner of insurance and the fire service coordinator of the division of fire services development with respect to the eligibility for, distribution of, use of, and accountability for, funds distributed pursuant to this section, see § 45-11-7.

Mississippi Windstorm Mitigation Coordinating Council created to develop and implement comprehensive, coordinated approach for windstorm mitigation, see § 83-1-201.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

OPINIONS OF THE ATTORNEY GENERAL

County Board of Supervisors may, in its discretion, appropriate funds made available to county for purpose of repayment of loan made by volunteer fire department for purchase of fire fighting equipment to be used in county, provided all other requirements statute are met. Henley, Jan. 24, 1990, A.G. Op. #90-0019.

Nonprofit volunteer fire departments are not bound by state's public purchasing laws notwithstanding all or portion of funding for such organizations comes from county; however, if county elects to make authorized purchases directly for organization, it must do so in accordance with public purchasing laws. Mord, Feb. 22, 1990, A.G. Op. #90-0123.

Funds may be used to purchase or finance fire fighting equipment for use in county by qualifying volunteer organizations whether or not equipment is titled to county; as for inventory, only that fire fighting equipment titled to county must be maintained on county's inventory, all other would be inventory of volunteer fire department notwithstanding it may have been purchased in whole or part with county funds. Mord, Feb. 22, 1990, A.G. Op. #90-0123.

Arson investigator, as member of sheriff's department, is subject to direction and control of sheriff, and sheriff may authorize arson investigator to work out of fire service coordinator's office and to perform additional duties there; county may provide that arson investigator's salary be paid from general fund budget rather than from sheriff's budget. Austin, August 26, 1992, A.G. Op. #92-0636.

Single notice by municipality to county that municipality provides its own fire protection service is sufficient to exempt municipality from fire protection levy; city need not give notice every year. Mitchell, August 26, 1992, A.G. Op. #92-0657.

Miss. Code Section 83-1-39 expressly authorizes counties to expend insurance rebate monies for capital construction for fire protection purposes; furthermore, this section authorizes counties to expend proceeds of fire protection levy for contracting with any provider of fire protection services. Crawford, Mar. 31, 1993, A.G. Op. #93-0174.

Section 83-1-39 clearly does not authorize use of insurance rebate funds for liability insurance purchases; however, it does allow county to expend such funds for fire protection "service contracts"; private nonprofit fire corporations receiving funds under proper "fire protection service contracts" would not be subject to same limitations. Dale Dec. 1, 1993, A.G. Op. #93-0812.

It is not a violation of Section 83-1-39 for county to allow use for non-fire purposes of available equipment and/or supplies that were obtained with "fire insurance rebate monies" as long as funds or use are reimbursed on pro rata basis. Gildea, Jan. 12, 1994, A.G. Op. #93-0596.

Provisions of Sections 19-3-73 and 83-1-39(9) are sufficiently broad to authorize county board of supervisors to pave parking and/or driveways of volunteer or municipal fire department. Trapp, Feb. 24, 1994, A.G. Op. #94-0079.

Insurance for volunteer fire department trucks may be paid out of insurance rebate monies paid to the private nonprofit volunteer fire departments in accordance with "fire protection service contracts" and the requirements of Section 83-1-39(6). See also, Section 19-5-95. Breland, February 15, 1995, A.G. Op. #95-0020.

Under Section 83-1-39(3)(a), county employees and equipment may be used to clean up debris left from the fire department training exercise if, as found on the minutes by the board of supervisors, the house was donated on the condition that the county would remove the debris after the fire department finished with the house. Barry, May 10, 1995, A.G. Op. #95-0187.

Under Section 83-1-39(3), fire hydrants may be characterized as capital construction or improvements. As such, if the board finds on its minutes, that the placing of the dry hydrants in ponds on private property, pursuant to a proper easement, will specifically benefit the fire department in the carrying out of its duties, such expenditure is permissible. Lee, June 15, 1995, A.G. Op. #95-0316.

A municipality may only purchase equipment, materials, supplies or provide funds for a fire protection district pursuant to an interlocal agreement with the fire protection district. Hatcher, October 30, 1998, A.G. Op. #98-0666.

As fire hydrants are a form of property that may be purchased by a fire protection district under the general authority of § 19-5-177(b), a fire protection district may acquire and install fire hydrants utilizing funds obtained from sources other than funds provided under this section, and may install such fire hydrants upon the water lines of a water and sewer district pursuant to an agreement with the latter district under the Interlocal Cooperation Act. Westbrook, July 30, 1999, A.G. Op. #99-0379.

As long as the county is meeting the requirements of the statute, the county need not contract with itself to receive or expend the funds set out therein. Clements, Apr. 5, 2002, A.G. Op. #02-0108.

There is no authority for a municipality to provide free water to a volunteer fire department for fund raising activities of the volunteer fire department. Campbell, Oct. 14, 2003, A.G. Op. 03-0503.

A county may not purchase property damage insurance on equipment and/or vehicles owned by the county volunteer fire departments through the use of the county's general fund or the county volunteer fire departments fund. Creekmore, Nov. 30, 2004, A.G. Op. 04-0560.

There is no express authority for a county to directly reimburse volunteer firemen for mileage in responding to fires within the county. However, the proceeds from the fire protection service contract may be used by a county fire district to reimburse volunteer firemen for mileage in responding to fires within the county. Mills, Nov. 30, 2004, A.G. Op. 04-0564.

Responsibility of inspections for fire code compliance of commercial establishments in Hancock County is that of the county appointed Fire Coordinator/Arson Investigator. Adam, Mar. 4, 2005, A.G. Op. 05-0049.

The County Arson Investigator has complete control over the scene of a fire pursuant to the law enforcement authority granted to him by the Hancock County Board of Supervisors and Sheriff as the Arson Investigator. Adam, Mar. 4, 2005, A.G. Op. 05-0049.

Where a county, through a contract with a volunteer fire department or fire protection service, allows such a service to use a county-owned vehicle, as the vehicle is still owned by the county, the department or service could not acquire insurance for the vehicle in its name. Nowak, Mar. 25, 2005, A.G. Op. 05-0031.

While a county may not use money from general fund, nor rebate funds under Section 83-1-39, to pay volunteer firemen directly, both of these funds can be used to pay fire departments under fire protection service contracts for their services. The fire department can then, if it so chooses, use these funds to pay individual firemen for their services on a per call basis. Hudson, Dec. 27, 2005, A.G. Op. 05-0579.

Based upon the authority granted to counties in Sections 19-3-72 and 83-1-39(9), and upon counties' authority to allow fire protection districts the use of county-owned vehicles and equipment, a county board of supervisors would have the authority to remove trees from real property owned by a fire protection district in the county. White, Sept. 22, 2006, A.G. Op. 06-0433.

§ 83-1-41. Repealed.

Repealed by Laws, 1990, ch 559, § 22, eff from and after July 1, 1990.

§ 83-1-41. [En Laws, 1979, ch 301, §§ 44, 45; Am Laws, 1979, ch. 357, § 21; Laws, 1982, ch. 366, § 19]

Editor's Notes — Former section 83-1-41 provided for the repeal of sections 83-1-1 through 83-1-39.

§ 83-1-43. Authority of commissioner to enforce federal "Health Insurance Portability and Accountability Act of 1996."

The Commissioner of Insurance may make use of any of the powers established under the insurance laws and regulations of this state to enforce the federal "Health Insurance Portability and Accountability Act of 1996." The commissioner may establish and, from time to time, amend the rules and regulations relating to the enforcement of and compliance with the "Health Insurance Portability and Accountability Act of 1996."

HISTORY: Laws, 1997, ch. 341, § 3, eff from and after passage (approved March 17, 1997).

Federal Aspects — The Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, is codified in various sections of 29 USCS (see 29 USCS §§ 1181 et seq.) and 42 USCS (see §§ 1320d et seq.).

§ 83-1-45. Commissioner of Insurance to adopt rules and regulations governing disclosure of nonpublic personal information by insurance licensees.

The Commissioner of Insurance may adopt any rules and regulations necessary to implement the provisions of the Gramm-Leach-Bliley Act of 1999 (Public Law 106-102), including, but not limited to, rules and regulations governing the disclosure by insurance licensees of nonpublic personal information.

HISTORY: Laws, 2001, ch. 306, § 1, eff from and after July 1, 2001.

Federal Aspects — The provisions of the Gramm-Leach-Bliley Act of 1999 (Public Law 106-102) are codified generally at 15 USCS §§ 6701 et seq.

§ 83-1-47. Commissioner of Insurance authorized to establish nonbinding, nonadversarial alternative dispute resolution procedure for personal lines insurance claims.

The Commissioner of Insurance may make use of any of the powers established under the insurance laws and regulations of this state to establish a nonbinding, nonadversarial alternative dispute resolution procedure for the effective, fair and timely handling of personal lines insurance claims. The commissioner may establish and, from time to time, amend the rules and regulations relating to the establishment and enforcement of this section.

HISTORY: Laws, 2006, ch. 316, § 1, eff from and after passage (approved Mar. 1, 2006).

§ 83-1-49. Power of commissioner to enjoin unlicensed activity.

(1) The Commissioner of Insurance shall have the power to examine and investigate into the affairs of every person, company, corporation or association engaged in the business of insurance in this state in order to determine whether such person, company, corporation or association has been or is engaged in any insurance activity without having first obtained a license as required by law.

(2) Whenever the commissioner shall have reason to believe, from evidence satisfactory to him, that any such person, company, corporation or association has engaged or is engaging in any unlicensed insurance activity in this state, the commissioner may issue a cease and desist order with or without notice and a prior hearing against the person, company, corporation or association engaged in the prohibited unlicensed activities, directing them to cease and desist from further unlicensed activities. If a cease and desist order is issued without notice and a hearing, the order shall specify that the respondent may request a hearing for reconsideration within twenty (20) days of the date of the order.

(3) Should any person, company, corporation or association fail or refuse to comply with the cease and desist order issued by the commissioner pursuant to subsection (2) of this section, such violation shall be a misdemeanor and, upon conviction, shall be punishable by a fine of not more than Five Thousand Dollars ($5,000.00) per violation.

HISTORY: Laws, 2015, ch. 422, § 1, eff from and after passage (approved Mar. 29, 2015).

Cross References — Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

§ 83-1-51. Power of commissioner to enjoin unauthorized activity in violation of any insurance law.

(1) The Commissioner of Insurance shall have the power to examine and investigate into the affairs of every person, company, corporation or association who holds a license to conduct the business of insurance in this state in order to determine whether such person, company, corporation or association has been or is engaged in any improper or unauthorized activity in violation of any insurance law.

(2) Whenever the commissioner shall have reason to believe, from evidence satisfactory to him, that any such person, company, corporation or

association has engaged or is engaging in any improper or unauthorized activity in violation of any insurance law, the commissioner may issue a cease and desist order with or without notice and a prior hearing against the person, company, corporation or association engaged in the prohibited activities, directing them to cease and desist from further activities. If a cease and desist order is issued without notice and a hearing, the order shall specify that the respondent may request a hearing for reconsideration within twenty (20) days of the date of the order.

(3) Should any person, company, corporation or association fail or refuse to comply with the cease and desist order issued by the commissioner pursuant to subsection (2) of this section, such violation shall be a misdemeanor and, upon conviction, shall be punishable by a fine of not more than Five Thousand Dollars ($5,000.00) per violation.

HISTORY: Laws, 2016, ch. 305, § 1, eff from and after July 1, 2016.

Cross References — Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

JURISDICTION OVER HEALTH CARE PROVIDERS

Sec.

83-1-101. Jurisdiction of Insurance Department; exception.
83-1-103. Proof to show jurisdiction of other body.
83-1-105. Examination to determine solvency and organization of person or entity furnishing services.
83-1-107. Application of provisions.
83-1-109. Disclosure of insurance provisions.

§ 83-1-101. Jurisdiction of Insurance Department; exception.

Notwithstanding any other provision of law to the contrary, and except as provided herein, any person or other entity which provides coverage in this state for medical, surgical, chiropractic, physical therapy, speech pathology, audiology, professional mental health, dental, hospital, or optometric expenses, whether such coverage is by direct payment, reimbursement, or otherwise, shall be presumed to be subject to the jurisdiction of the State Insurance Department, unless (a) the person or other entity shows that while providing such services it is subject to the jurisdiction of another agency of this state, any subdivisions thereof, or the federal government; or (b) the person or other entity is providing coverage under the Direct Primary Care Act in Sections 83-81-1 through 83-81-11.

HISTORY: Laws, 1989, ch. 351, § 1; Laws, 2015, ch. 369, § 7, eff from and after July 1, 2015.

Cross References — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

RESEARCH REFERENCES

Practice References.

Business Law Monographs, Volume IN1—Business Uses of Life Insurance (Matthew Bender Elite Products).

Business Law Monographs, Volume IN2—Casualty and Liability Insurance (Matthew Bender elite Products).

Insuring Real Property (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-1-103. Proof to show jurisdiction of other body.

A person or entity may show that it is subject to the jurisdiction of another agency of this state, any subdivision thereof, or the federal government, by providing to the Insurance Commissioner the appropriate certificate, license or other document issued by the other governmental agency which permits or qualifies it to provide those services.

HISTORY: Laws, 1989, ch. 351, § 2, eff from and after July 1, 1989.

Cross References — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

§ 83-1-105. Examination to determine solvency and organization of person or entity furnishing services.

Any person or entity which is unable to show under Section 83-1-103 that it is subject to the jurisdiction of another agency of this state, any subdivision thereof, or the federal government, shall submit to an examination by the Insurance Commissioner to determine the organization and solvency of the person or the entity, and to determine whether or not such person or entity complies with the applicable provisions of Sections 83-1-101 through 83-1-109 and all laws of this state.

HISTORY: Laws, 1989, ch. 351, § 3, eff from and after July 1, 1989.

Cross References — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

§ 83-1-107. Application of provisions.

Any person or entity unable to show that it is subject to the jurisdiction of another agency of this state, any subdivision thereof, or the federal government, shall be subject to all appropriate provisions of Section 83-1-101 and all laws of this state regarding the conduct of its business.

HISTORY: Laws, 1989, ch. 351, § 4, eff from and after July 1, 1989.

Cross References — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

§ 83-1-109. Disclosure of insurance provisions.

Any production agency or administrator which advertises, sells, transacts, or administers the coverage in this state described in Section 83-1-101 and which is required to submit to an examination by the Insurance Commissioner under Section 83-1-105 shall, if said coverage is not fully insured or otherwise fully covered by an admitted life or disability insurer, nonprofit hospital service plan, or nonprofit health care plan, advise every purchaser, prospective purchaser and covered person of such lack of insurance or other coverage.

Any administrator which advertises or administers the coverage in this state described in Section 83-1-101 and which is required to submit to an examination by the Insurance Commissioner under Section 83-1-105, shall advise any production agency of the elements of the coverage, including the amount of "stop-loss" insurance in effect.

HISTORY: Laws, 1989, ch. 351, § 5, eff from and after July 1, 1989.

Cross References — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

ADMINISTRATIVE SUPERVISION OF INSURERS BY COMMISSIONER OF INSURANCE

Sec.

83-1-151. Definitions.
83-1-153. Application of provisions.
83-1-155. Basis for administrative supervision; notice; appeals; hearings; release from supervision.
83-1-157. Confidentiality of records, etc.; exceptions.
83-1-159. Administrative supervisor; prohibited activities of insurer.
83-1-161. Right of insurer to contest action taken or proposed to be taken by supervisor; appeals.
83-1-163. Right of commissioner to initiate judicial proceedings, liquidation proceedings, or other delinquency proceedings.
83-1-165. Adoption of rules by commissioner.
83-1-167. Right of commissioner to meet with supervisor, or his representative, without presence of any other person.
83-1-169. Immunity from liability.

§ 83-1-151. Definitions.

As used in Sections 83-1-151 through 83-1-169, the following items shall have the meanings ascribed herein unless the context indicates otherwise:

(a) "Insurer" means and includes every person engaged as indemnitor, surety or contractor in the business of entering into contracts of insurance or of annuities as limited to:

(i) Any insurer who is doing an insurer business, or has transacted insurance in this state, and against whom claims arising from that transaction may exist now or in the future.

(ii) Any fraternal benefit society or larger fraternal benefit society or larger fraternal benefit society which is subject to the provisions of Section 83-29-1 et seq. or Section 83-30-1 et seq.

(iii) All corporate bodies organized for the purpose of carrying on the business of mutual insurance subject to the provisions of Section 83-31-1 et seq.

(iv) All health maintenance organizations established under Section 41-7-401.

(b) "Exceeded its powers" means the following conditions:

(i) The insurer has refused to permit examination of its books, papers, accounts, records or affairs by the commissioner, his deputies, employees or duly commissioned examiners;

(ii) A domestic insurer has unlawfully removed from this state books, papers, accounts or records necessary for an examination of the insurer;

(iii) The insurer has failed to promptly comply with the applicable financial reporting statutes or rules and departmental requests relating thereto;

(iv) The insurer has neglected or refused to comply with an order of the commissioner to make good, within the time prescribed by law, any prohibited deficiency in its capital, capital stock or surplus;

(v) The insurer is continuing to transact insurance or write business after its license has been revoked or suspended by the commissioner;

(vi) The insurer, by contract or otherwise, has unlawfully or has in violation of an order of the commissioner or has without first having obtained written approval of the commissioner if approval is required by law:

(A) Totally reinsured its entire outstanding business, or

(B) Merged or consolidated substantially its entire property or business with another insurer;

(vii) The insurer engaged in any transaction in which it is not authorized to engage under the laws of this state;

(viii) The insurer refused to comply with a lawful order of the commissioner.

(c) "Consent" means agreement to administrative supervision by the insurer.

(d) "Commissioner" means the Commissioner of Insurance.

(e) "Department" means the Department of Insurance.

HISTORY: Laws, 1991, ch. 377, § 1; Laws, 1994, ch. 422, § 1; Laws, 1997, ch. 307, § 3; Laws, 2004, ch. 343, § 1, eff from and after July 1, 2004.

Editor's Notes — Section 41-7-401 referred to in (a) (iv) was repealed by Laws, 1995, ch. 613, § 35, eff from and after July 1, 1995. For similar provisions, see §§ 83-41-301 et seq.

§ 83-1-153. Application of provisions.

The provisions of Sections 83-1-151 through 83-1-169 shall apply to:

(a) All domestic insurers, and

(b) Any other insurer doing business in this state whose state of domicile has asked the commissioner to apply the provisions of Sections 83-1-151 through 83-1-169 to such insurer.

HISTORY: Laws, 1991, ch. 377, § 2, eff from and after July 1, 1991.

§ 83-1-155. Basis for administrative supervision; notice; appeals; hearings; release from supervision.

(1) An insurer may be subject to administrative supervision by the commissioner if upon examination or at any other time it appears in the commissioner's discretion that:

(a) The insurer's condition renders the continuance of its business hazardous to the public or to its insureds;

(b) The insurer has exceeded its powers granted under its certificate of authority and applicable law;

(c) The insurer has failed to comply with the applicable provisions of the insurance code;

(d) The business of the insurer is being conducted fraudulently; or

(e) The insurer gives its consent.

(2) If the commissioner determines that the conditions set forth in subsection (1) of this section exist, the commissioner shall:

(a) Notify the insurer of such determination;

(b) Furnish to the insurer a written list of the requirements to abate this determination; and

(c) Notify the insurer that it is under the supervision of the commissioner and that the commissioner is applying and effectuating the provisions of Sections 83-1-151 through 83-1-169. Such action by the commissioner may be appealed to the Chancery Court of the First Judicial District of Hinds County.

(3) If placed under administrative supervision, the insurer shall have sixty (60) days, or another period of time as designated by the commissioner, to comply with the requirements of the commissioner subject to the provisions of Sections 83-1-151 through 83-1-169.

(4) If it is determined after notice and hearing that the conditions giving rise to the supervision still exist at the end of the supervision period specified above, the commissioner may extend such period.

(5) If it is determined that none of the conditions giving rise to the supervision exist, the commissioner shall release the insurer from supervision.

HISTORY: Laws, 1991, ch. 377, § 3, eff from and after July 1, 1991.

Cross References — Administrative supervisor, see § 83-1-159.
Prohibited activities during administrative supervision, see § 83-1-159.

§ 83-1-157. Confidentiality of records, etc.; exceptions.

(1) The proceedings, hearings, notices, correspondence, reports, records and other information in the possession of the commissioner or the department relating to the supervision of any insurer are confidential except as provided by this section.

(2) The personnel of the department shall have access to these proceedings, hearings, notices, correspondence, reports, records or information as permitted by the commissioner.

(3) The commissioner may open the proceedings or hearings or disclose the notices, correspondence, reports, records or information to a department, agency or instrumentality of this or another state or the United States if the commissioner determines that the disclosure is necessary or proper for the enforcement of the laws of this or another state of the United States.

(4) The commissioner may open the proceedings or hearings or make public the notices, correspondence, reports, records or other information if the commissioner deems that it is in the best interest of the public or in the best interest of the insurer, its insureds, creditors or the general public.

(5) This section does not apply to hearings, notices, correspondence, reports, records or other information obtained upon the appointment of a receiver for the insurer by a court of competent jurisdiction.

HISTORY: Laws, 1991, ch. 377, § 4, eff from and after July 1, 1991.

§ 83-1-159. Administrative supervisor; prohibited activities of insurer.

During the period of supervision, the commissioner or his designated appointee shall serve as the administrative supervisor. The commissioner may provide that the insurer may not do any of the following things during the period of supervision, without the prior approval of the commissioner or his appointed supervisor:

(a) Dispose of, convey or encumber any of its assets or its business in force;

(b) Withdraw any of its bank accounts;

(c) Lend any of its funds;

(d) Invest any of its funds;

(e) Transfer any of its property;

(f) Incur any debt, obligation or liability;

(g) Merge or consolidate with another company;

(h) Approve new premiums or renew any policies;

(i) Enter into any new reinsurance contract or treaty;

(j) Terminate, surrender, forfeit, convert or lapse any insurance policy, certificate or contract, except for nonpayment of premiums due;

(k) Release, pay or refund premium deposits, accrued cash or loan values, unearned premiums, or other reserves on any insurance policy, certificate or contract;

(*l*) Make any material change in management; or

(m) Increase salaries and benefits of officers or directors or the preferential payment of bonuses, dividends or other payments deemed preferential.

HISTORY: Laws, 1991, ch. 377, § 5, eff from and after July 1, 1991.

Cross References — Basis for administrative supervision, see § 83-1-155.

RESEARCH REFERENCES

ALR.

What constitutes waiver by insured or insured's agent of required notice of cancellation of insurance policy. 86 A.L.R.4th 886.

§ 83-1-161. Right of insurer to contest action taken or proposed to be taken by supervisor; appeals.

During the period of supervision the insurer may contest an action taken or proposed to be taken by the supervisor specifying the manner wherein the action being complained of would not result in improving the condition of the insurer. Denial of the insurer's request upon reconsideration entitles the insurer to appeal to the Chancery Court of the First Judicial District of Hinds County.

HISTORY: Laws, 1991, ch. 377, § 6, eff from and after July 1, 1991.

§ 83-1-163. Right of commissioner to initiate judicial proceedings, liquidation proceedings, or other delinquency proceedings.

Nothing contained in Sections 83-1-151 through 83-1-169 shall preclude the commissioner from initiating judicial proceedings to place an insurer in conservation, rehabilitation or liquidation proceedings or other delinquency proceedings, however designated under the laws of this state, regardless of whether the commissioner has previously initiated administrative supervision proceedings under Sections 83-1-151 through 83-1-169 against the insurer.

HISTORY: Laws, 1991, ch. 377, § 7, eff from and after July 1, 1991.

§ 83-1-165. Adoption of rules by commissioner.

The commissioner is empowered to adopt reasonable rules necessary for the implementation of Sections 83-1-151 through 83-1-169.

HISTORY: Laws, 1991, ch. 377, § 8, eff from and after July 1, 1991.

§ 83-1-167. Right of commissioner to meet with supervisor, or his representative, without presence of any other person.

The commissioner may meet with a supervisor appointed under Sections 83-1-151 through 83-1-169 and with the attorney or other representative of the supervisor, without the presence of any other person, at the time of any proceeding or during the pendency of any proceeding held under authority of Sections 83-1-151 through 83-1-169 to carry out the commissioner's duties under Sections 83-1-151 through 83-1-169 or for the supervisor to carry out his duties under Sections 83-1-151 through 83-1-169.

HISTORY: Laws, 1991, ch. 377, § 9, eff from and after July 1, 1991.

§ 83-1-169. Immunity from liability.

There shall be no liability on the part of, and no cause of action of any nature shall arise against, the commissioner or the department or its employees or agents for any action taken by them in the performance of their powers and duties under Sections 83-1-151 through 83-1-169.

HISTORY: Laws, 1991, ch. 377, § 10, eff from and after July 1, 1991.

COMPREHENSIVE HURRICANE DAMAGE MITIGATION PROGRAM

Sec.
83-1-191. Comprehensive hurricane damage mitigation program established; cost-benefit study on wind hazard mitigation construction measures; inspections; financial grants for residential retrofits; public education; advisory council; rules and regulations [Repealed effective July 1, 2025].

§ 83-1-191. Comprehensive hurricane damage mitigation program established; cost-benefit study on wind hazard mitigation construction measures; inspections; financial grants for residential retrofits; public education; advisory council; rules and regulations [Repealed effective July 1, 2025].

(1) There is established within the Department of Insurance a Comprehensive Hurricane Damage Mitigation Program. This section does not create an entitlement for property owners or obligate the state in any way to fund the inspection or retrofitting of residential property or commercial property in this state. Implementation of this program is subject to the availability of funds that may be appropriated by the Legislature for this purpose. The program may develop and implement a comprehensive and coordinated approach for hurricane damage mitigation that may include the following:

(a) **Cost-benefit study on wind hazard mitigation construction measures.** The performance of a cost-benefit study to establish the most appropriate wind hazard mitigation construction measures for both new construction and the retrofitting of existing construction for both residential and commercial facilities within the wind-borne debris regions of Mississippi as defined by the International Building Code. The recommended wind construction techniques shall be based on both the newly adopted Mississippi building code sections for wind load design and the wind-borne debris region. The list of construction measures to be considered for evaluation in the cost-benefit study shall be based on scientifically established and sound, but common, construction techniques that go above and beyond the basic recommendations in the adopted building codes. This allows residents to utilize multiple options that will further reduce risk and loss and still be awarded for their endeavors with appropriate wind insurance discounts. It is recommended that existing accepted scientific studies that validate the wind hazard construction techniques benefits and effects be taken into consideration when establishing the list of construction techniques that homeowners and business owners can employ. This will ensure that only established construction measures that have been studied and modeled as successful mitigation measures will be considered to reduce the chance of including risky or unsound data that will cost both the property owner and state unnecessary losses. The cost-benefit study shall be based on actual construction cost data collected for several types of residential construction and commercial construction materials, building techniques and designs that are common to the region. The study shall provide as much information as possible that will enhance the data and options provided to the public, so that homeowners and business owners can make informed and educated decisions as to their level of involvement. Based on the construction data, modeling shall be performed on a variety of residential and commercial designs, so that a broad enough representative spectrum of data can be obtained. The data from the study will be utilized in a report to establish tables reflecting actuarially appropriate levels of wind insurance discounts (in percentages) for each mitigation construction technique/combination of techniques. This report will be utilized as a guide for the Department of Insurance and the insurance industry for developing actuarially appropriate discounts, credits or other rate differentials, or appropriate reductions in deductibles, for properties on which fixtures or construction techniques demonstrated to reduce the amount of loss in a windstorm have been installed or implemented. Additional data that will enhance the program, such as studies to reflect property value increases for retrofitting or building to the established wind hazard mitigation construction techniques and cost comparison data collected to establish the value of this program against the investment required to include the mitigation measures, also may be provided.

(b) **Wind certification and hurricane mitigation inspections.**

(i) Home-retrofit inspections of site-built, residential property, including single-family, two-family, three-family or four-family residential units, and a set of representative commercial facilities may be offered to determine what mitigation measures are needed and what improvements to existing residential properties are needed to reduce the property's vulnerability to hurricane damage. A state program may be established within the Department of Insurance to provide homeowners and business owners wind certification and hurricane mitigation inspections. The inspections provided to homeowners and business owners, at a minimum, must include:

1. A home inspection and report that summarizes the results and identifies corrective actions a homeowner may take to mitigate hurricane damage.
2. A range of cost estimates regarding the mitigation features.
3. Insurer-specific information regarding premium discounts correlated to recommended mitigation features identified by the inspection.

4. A hurricane resistance rating scale specifying the home's current as well as projected wind resistance capabilities.

This data may be provided by trained and certified inspectors in standardized reporting formats and forms to ensure all data collected during inspections is equivalent in style and content that allows construction data, estimates and discount information to be easily assimilated into a database. Data pertaining to the number of inspections and inspection reports may be stored in a state database for evaluation of the program's success and review of state goals in reducing wind hazard loss in the state.

(ii) To qualify for selection by the department as a provider of wind certification and hurricane mitigation inspections services, the entity shall, at a minimum, and on a form and in the manner prescribed by the commissioner:

1. Use wind certification and hurricane mitigation inspectors who:

a. Have prior experience in residential and/or commercial construction or inspection and have received specialized training in hurricane mitigation procedures through the state certified program. In order to qualify for training in the inspection process, the individual should be either a licensed building code official, a licensed contractor or inspector in the State of Mississippi, or a civil engineer.

b. Have undergone drug testing and background checks.

c. Have been certified through a state mandated training program, in a manner satisfactory to the department, to conduct the inspections.

d. Have not been convicted of a felony crime of violence or of a sexual offense; have not received a first-time offender pardon or nonadjudication order for a felony crime of violence or of a sexual offense; or have not entered a plea of guilty or nolo contendere to a felony charge of violence or of a sexual offense.

e. Submit a statement authorizing the Commissioner of Insurance to order fingerprint analysis or any other analysis or documents deemed necessary by the commissioner for the purpose of verifying the criminal history of the individual. The commissioner shall have the authority to conduct criminal history verification on a local, state or national level, and shall have the authority to require the individual to pay for the costs of such criminal history verification.

2. Provide a quality assurance program including a reinspection component.

3. Have data collection equipment and computer systems, so that data can be submitted electronically to the state's database of inspection reports, insurance certificates, and other industry information related to this program. It is mandatory that all inspectors provide original copies to the property owner of any inspection reports, estimates, etc., pertaining to the inspection and keep a copy of all inspection materials on hand for state audits.

(c) **Financial grants to retrofit properties.** Financial grants may be used to encourage single-family, site-built, owner-occupied, residential property owners or commercial property owners to retrofit their properties to make them less vulnerable to hurricane damage.

(d) **Education and consumer awareness.** Multimedia public education, awareness and advertising efforts designed to specifically address mitigation techniques may be employed, as well as a component to support ongoing consumer resources and referral services. In addition, all insurance companies shall provide notification to their clients regarding the availability of this program, participation details, and directions to the state website promoting the program, along with appropriate contact phone numbers to the state agency administrating the program. The notification to the clients must be sent by the insurance company within thirty (30) days after filing their insurance discount schedules with the Department of Insurance.

(e) **Advisory council.** There is created an advisory council to provide advice and assistance to the program administrator with regard to his or her administration of the program. The advisory council shall consist of:

(i) An agent, selected by the Independent Insurance Agents of Mississippi.

(ii) Two (2) representatives of residential property insurers, selected by the Department of Insurance.

(iii) One (1) representative of homebuilders, selected by the Home Builders Association of Mississippi.

(iv) The Chairman of the House Insurance Committee, or his designee.

(v) The Chairman of the Senate Insurance Committee, or his designee.

(vi) The Executive Director of the Mississippi Windstorm Underwriting Association, or his designee.

(vii) The Director of the Mississippi Emergency Management Agency, or his designee.

Members appointed under subparagraphs (i) and (ii) shall serve at the pleasure of the Department of Insurance. All other members shall serve as voting ex officio members. Members of the advisory council who are not legislators, state officials or state employees shall be compensated at the per diem rate authorized by Section 25-3-69, and shall be reimbursed in accordance with Section 25-3-41, for mileage and actual expenses incurred in the performance of their duties. Legislative members of the advisory council shall be paid from the contingent expense funds of their respective houses in the same manner as provided for committee meetings when the Legislature is not in session; however, no per diem or expense for attending meetings of the advisory council may be paid while the Legislature is in session. No advisory council member may incur per diem, travel or other expenses unless previously authorized by vote, at a meeting of the council, which action shall be recorded in the official minutes of the meeting. Nonlegislative members shall be paid from any funds made available to the advisory council for that purpose.

(f) **Rules and regulations.** The Department of Insurance may adopt rules and regulations governing the Comprehensive Hurricane Damage

Mitigation Program. The department also may adopt rules and regulations establishing priorities for grants provided under this section based on objective criteria that gives priority to reducing the state's probable maximum loss from hurricanes. However, pursuant to this overall goal, the department may further establish priorities based on the insured value of the dwelling, whether or not the dwelling is insured by the Mississippi Windstorm Underwriting Association and whether or not the area under consideration has sufficient resources and the ability to perform the retrofitting required.

(2) Nothing in this section shall prohibit the Department of Insurance from entering into an agreement with any other appropriate state agency to assist with or perform any of the duties set forth hereunder.

(3) This section shall stand repealed from and after July 1, 2025.

HISTORY: Laws, 2007, ch. 524, § 4; Laws, 2009, ch. 537, § 1; Laws, 2010, ch. 313, § 1; Laws, 2012, ch. 307, § 1; Laws, 2015, ch. 319, § 1, eff from and after July 1, 2015; Laws, 2018, ch. 398, § 1, eff from and after July 1, 2018; reenacted and amended, Laws, 2021, ch. 363, § 1, eff from and after July 1, 2021.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in the seventh sentence of subsection (1)(a) by substituting "cost data collected for several" for "cost date collected for both several." The Joint Committee ratified the correction at its July 22, 2010, meeting.

Amendment Notes — The 2021 amendment reenacted and amended the section by substituting "July 1, 2025" for "July 1, 2021" in (3) to extend the date of the repealer for the section.

Cross References — State agencies and public officials providing information about the agency or office to the public on a website are required to regularly review and update that information, see § 25-1-117.

RESEARCH REFERENCES

Practice References.

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

Business Law Monographs, Volume IN2—Casualty and Liability Insurance (Matthew Bender elite Products).

Insuring Real Property (Matthew Bender Elite Products).

MISSISSIPPI WINDSTORM MITIGATION COORDINATING COUNCIL

Sec.
83-1-201. Creation; purpose; composition; meetings; Mississippi Building Codes Council to serve as advisory council; Mississippi Windstorm Mitigation Fund.

§ 83-1-201. Creation; purpose; composition; meetings; Mississippi Building Codes Council to serve as advisory council; Mississippi Windstorm Mitigation Fund.

(1) There is created the Mississippi Windstorm Mitigation Coordinating Council for the purpose of developing and implementing a comprehensive and coordinated approach for windstorm mitigation. The council shall consist of the following:

(a) The Commissioner of Insurance, or his designee, to serve ex officio;

(b) The Chairman of the Board of Directors of the Mississippi Insurance Windstorm Underwriting Association, or his designee, to serve ex officio;

(c) Two (2) members who are property and casualty insurance providers appointed by the Governor, to serve at his will and pleasure;

(d) Two (2) members who are insurance producers from the Coast Area, as defined under Section 83-34-1, appointed by the Commissioner of Insurance, to serve at his will and pleasure;

(e) One (1) member from the Home Builders Association of Mississippi or the State Board of Contractors appointed by the Commissioner of Insurance, to serve at his will and pleasure;

(f) One (1) nonvoting member from the Institute for Business and Home Safety appointed by the Governor, to serve at his will and pleasure;

(g) One (1) member who is a representative of the state institutions of higher learning appointed by the Commissioner of Higher Education to serve at his will and pleasure, nonvoting;

(h) The Director of the Mississippi State Rating Bureau, or his designee, to serve ex officio, nonvoting; and

(i) The Chief Deputy State Fire Marshal, or his designee, to serve ex officio, nonvoting.

(2) The Commissioner of Insurance shall convene the first meeting of the council within ninety (90) days of July 1, 2011, and shall act as temporary chairman until the council elects from its members a chairman and vice chairman. The council shall adopt regulations consistent with this section, subject to the approval of the Commissioner of Insurance. The council may also consider the mitigation measures and initiatives referenced under Section 83-1-191 in developing and implementing a windstorm mitigation program. A meeting may be called by the chairman on his own initiative and must be called by him at the request of three (3) or more members of the council. Each member must be notified by the chairman in writing of the time and place of the meeting at least seven (7) days before the meeting. Four (4) voting members constitute a quorum. Each meeting is open to the public. An official decision of the council may be made only by a vote of a majority of those voting members in attendance at the meeting.

(3) The Mississippi Building Codes Council created under Section 17-2-3 shall serve as an advisory council to the council created under this section.

(4)(a) There is created in the State Treasury a special fund to be designated as the "Mississippi Windstorm Mitigation Fund." The fund shall consist of monies appropriated by act of the Legislature and monies from any other public or private source designated for deposit into the fund. Unexpended amounts remaining in the fund at the end of a fiscal year shall not lapse into the State General Fund, and any interest earned or investment earnings on amounts in the fund shall be deposited to the credit of the fund.

(b) Monies in the special fund may be used by the Department of Insurance, upon appropriation by the Legislature, only for the purposes of assisting the Mississippi Windstorm Mitigation Coordinating Council in developing and implementing a comprehensive and coordinated approach for windstorm mitigation including providing grants, developing education programs, providing funds for training local officials or providing any other assistance consistent with these purposes.

HISTORY: Laws, 2011, ch. 460, § 1, eff from and after July 1, 2011.

CHAPTER 2.

COMPETITIVE RATING FOR PROPERTY AND CASUALTY INSURANCE

Sec.
83-2-1. Applicability of chapter and types of insurance excepted; definitions.
83-2-3. Standards applicable to rates; criteria for determining compliance; commissioner to establish uniform policy language regarding applicability of hurricane deductibles and form of notice under certain homeowner's insurance policies.
83-2-5. Filing of rates and related information by residual market mechanisms.
83-2-7. Filing of rates and related information by insurers; exceptions; effective date of rate adjustment filing; exemption of certain commercial lines insurance coverages from filing and approval requirements.
83-2-9. Public inspection of filed rates and related information; rates exceeding those filed; filing by rate service organization; filing by reference.
83-2-11. Disapproval of rates by commissioner and related procedure; interim rates in absence of legally effective rates.
83-2-13. Furnishing rate information to insureds; hearing of complaints as to application of rating system; appeals.
83-2-15. Rating bureau as exclusive provider of services relating to rates; licensing of and services provided by rate service organization.
83-2-17. Advisory organizations; registration; unfair practices.
83-2-19. Repealed.
83-2-21. Prohibition of insurer agreements as to adherence to or use of rates and related information; exception for insurers under common ownership or management.
83-2-23. Cooperation among insurers participating in joint underwriting, pools, residual market mechanisms; registration with and review by commissioner; unfair practices.
83-2-25. Compliance review; related reports and records.
83-2-27. Payment of dividends, savings or unabsorbed premium deposits to insureds.
83-2-29. Penalties; procedures for license suspension.
83-2-31. Appeals; rates charged pending disposition of appeal.
83-2-33. Property and casualty insurance companies to contribute to Insurance Department Fund; funding of agency expenses; deposit of monies into State General Fund.
83-2-35. Payment of fee by property and casualty insurers; deposit of fee into Insurance Department Fund; funding of agency expenses; deposit of monies into State General Fund.

§ 83-2-1. Applicability of chapter and types of insurance excepted; definitions.

(1) This chapter applies to all forms of property and casualty insurance on risks or operations in this state by any insurer authorized to do business in this state, except:

(a) Accident and health;

(b) Ocean marine insurance;

(c) Reinsurance;

(d) Aircraft liability and aircraft hull insurance;

(e) Title insurance;

(f) Credit accident and health insurance.

(2) As used in this chapter:

(a) "Advisory organization" means any person or organization, other than a rate service organization, which assists insurers as authorized by § 83-2-9(3).

(b) "Joint underwriting" means a voluntary arrangement established on an ad hoc basis to provide insurance coverage for a risk pursuant to which two (2) or more insurers separately contract with the insured at a price and under policy terms agreed upon between the insurers.

(c) "Pool" means a voluntary arrangement other than a residual market mechanism, established on an ongoing basis, pursuant to which two (2) or more insurers participate in the sharing of risks on a predetermined basis. The pool may operate through an association, syndicate or other pooling agreement.

(d) "Rate service organization" means any person or organization which assists insurers in ratemaking or filing as authorized by § 83-2-9.

(e) The terms "rate service organization" and "advisory organization" do not include joint underwriting organizations, actuarial, legal or other consultants, a single insurer, any employees of an insurer, or insurers under common control or management or their employees or managers.

(f) "Residual market mechanism" means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment among them of insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods.

(g) "Supplementary rate information" includes any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, and any other similar information needed to determine the applicable rate in effect or to be in effect.

(h) "Supporting information" means (i) the experience and judgment of the filer and the experience or data of other insurers or organizations relied upon by the filer, (ii) the interpretation of any statistical data relied upon by the filer, (iii) a description of methods used in making the rates, and (iv) other similar information relied upon by the filer.

HISTORY: Laws, 1987, ch. 422, § 2, eff from and after January 1, 1988.

Federal Aspects — Regulation and taxation of business of insurance by states, 15 USCS §§ 1011, 1012.

JUDICIAL DECISIONS

ANALYSIS

1.-5. [Reserved for future use.]
6. Under former § 83-3-101.
7. Under former § 83-3-103.
8. Under former § 83-3-117.

1.-5. [Reserved for future use.]

6. Under former § 83-3-101.

The Casualty Rating Law of 1946 does not operate to amend or repeal pro tanto the Fire Rating Law of 1924, but both must be construed together so as to reconcile and give full effect to all provisions in both where reasonably possible. Insurance Co. of North America v. Insurance Com. of State, 237 Miss. 759, 116 So. 2d 224, 1959 Miss. LEXIS 529 (Miss. 1959).

7. Under former § 83-3-103.

The provision that if any kind of insurance subject to the act is also subject to regulation by another rate act, an insurer to which both acts are otherwise applicable shall designate which shall be applied, does not entitle an insurer to file with the commission a policy giving both fire and casualty coverage under a single indivisible premium, where fire insurance rates are subject to statutory control. Insurance Co. of North America v. Insurance Com. of State, 237 Miss. 759, 116 So. 2d 224, 1959 Miss. LEXIS 529 (Miss. 1959).

8. Under former § 83-3-117.

Under its general power to make necessary rules and regulations for the administration of the Fire Rating Law and the Casualty Insurance Law, the commission has the authority to approve or disapprove the form of insurance policies. Mississippi Ins. Com. v. Mississippi State Rating Bureau, 220 So. 2d 328, 1969 Miss. LEXIS 1456 (Miss. 1969).

It is evident from the wording of Code 1942, §§ 5816 and 5834-07(b) that the legislature intended that the insurance commission should have ample power to administer effectively the statutes controlling fire and casualty insurance. Mississippi Ins. Com. v. Mississippi State Rating Bureau, 220 So. 2d 328, 1969 Miss. LEXIS 1456 (Miss. 1969).

RESEARCH REFERENCES

ALR.

What constitutes “vacant land” within meaning of liability or property insurance policy provisions. 47 A.L.R.5th 535.

Am. Jur.

43 Am. Jur. 2d, Insurance § 69.

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Validity, construction, and application of McCarran-Ferguson Act (15 USCS §§ 1011-1015), dealing with regulation of insurance business by state or federal law. 21 L. Ed. 2d 938.

Practice References.

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§ 83-2-3. Standards applicable to rates; criteria for determining compliance; commissioner to establish uniform policy language regarding applicability of hurricane deductibles and form of notice under certain homeowner’s insurance policies.

(1) Rates shall comply with the following standards:

(a) Rates shall not be excessive, inadequate or unfairly discriminatory.

(b) A rate is excessive if it is likely to produce a profit that is unreasonably high for the insurance provided or if the expense provision included therein is unreasonably high in relation to the services rendered.

(c) A rate is inadequate if it threatens the solvency of the insurance company or tends to create a monopoly.

(d) Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses. A rate is not unfairly discriminatory because different premiums result for policyholders with like loss exposures with different expenses, or like expenses but different loss exposures, so long as the rate reflects the differences with reasonable accuracy.

(2) In determining whether rates comply with the standards set forth in subsection (1), the following criteria shall apply:

(a) Due consideration shall be given to past and prospective loss and expense experience within and outside this state; to catastrophe hazards; to any residual market loss redistributions and other similar obligations; to a reasonable provision for profit and contingencies; to trends within and outside this state; to loadings for leveling premium rates over a reasonable period of time or for dividends or savings to be allowed or returned by insurers to their policyholders, members or subscribers; and to all other relevant factors, including the judgment of the filer.

(b) Risks may be classified in any reasonable way for the establishment of rates except that no risks may be grouped by classifications based, in whole or in part, on race, color, creed, or national origin of the risk. Rates may be modified for individual risks in accordance with rating plans or schedules which provide for recognition of probable variations in hazards, expenses or both.

(c) The systems of expense provisions included in rates for use by an insurer or group of insurers may differ from those of other insurers or group of insurers to reflect the operating methods of such insurer or group with respect to any kind of insurance, or with respect to any subdivision or combination thereof.

(d) Any homeowners' insurance policy filed with the Commissioner of Insurance that offers a percentage deductible for the peril of windstorm from a named storm shall offer a buy-back provision for that deductible which is actuarially sound; however, the Commissioner of Insurance may grant a waiver from the mandatory buy-back provision in accordance with the following procedure and criteria:

(i) An insurance company shall make a formal filing requesting a waiver from the buy-back provision requirement with the Commissioner of Insurance.

(ii) An insurance company shall submit written proof in its formal filing as to why it is in the best interest of Mississippi policyholders to receive a waiver from the buy-back provision requirement and shall provide any supporting documentation requested by the commissioner deemed appropriate to make his decision.

(iii) All expenses incurred by the Commissioner of Insurance or his designee in determining the validity of the waiver request shall be borne by the petitioning insurer. Such expenses may include, but not be limited to, the cost of reviewing the filing by actuaries, and if the commissioner deems a public hearing appropriate, the cost of a facility, the cost of publicity and the cost of a court reporter for the hearing.

(e) The commissioner shall establish by regulation uniform policy language regarding the applicability of hurricane deductibles and the form of notice to be provided to an insured under a homeowner's insurance policy by an insurer utilizing a hurricane deductible program or programs. The term "hurricane," for the purpose of a hurricane deductible program, means a storm system that has been declared to be a hurricane by the National Hurricane Center of the National Weather Service. The duration of the hurricane includes the time period, in Mississippi:

(i) Beginning at the time a hurricane watch or hurricane warning is issued for any part of Mississippi by the National Hurricane Center of the National Weather Service;

(ii) Continuing for the time period during which the hurricane conditions exist anywhere in Mississippi; and

(iii) Ending twenty-four (24) hours following the termination of the last hurricane watch or hurricane warning issued for any part of Mississippi by the National Hurricane Center of the National Weather Service.

(3) To ensure the most appropriate use of state resources with respect to the engagement of actuarial services for the review of rate filings under this chapter, the commissioner may adopt rules and regulations to establish the criteria and procedures for determining when a rate filing should be submitted to an actuary for review.

HISTORY: Laws, 1987, ch. 422, § 3; Laws, 1999, ch. 468, § 1; Laws, 2014, ch. 380, § 1, eff from and after July 1, 2014; Laws, 2020, ch. 447, § 2, eff from and after July 1, 2020.

JUDICIAL DECISIONS

1. Private cause of action.

Miss. Code Ann. § 83-2-3 was regulatory in nature and afforded no private right of action; the Mississippi Commissioner of Insurance was charged with enforcement of § 83-2-3. Miss. Code Ann. § 83-2-29(1). The defendant correctly stated that the plaintiff confessed the excessive rate standards claim, and the parties agreed that no private cause of action existed under Miss. Code Ann. § 83-2-3; therefore, the court granted summary judgment in favor of the defendant as to the plaintiff's excessive rate standards claim. Mullen v. Nationwide Mut. Ins. Co., 2013 U.S. Dist. LEXIS 7679 (S.D. Miss. Jan. 18, 2013).

Plaintiffs may not state a private cause of action against a defendant under Miss. Code Ann. § 83-2-3. Wells v. Shelter Gen. Ins. Co., 217 F. Supp. 2d 744, 2002 U.S. Dist. LEXIS 14931 (S.D. Miss. 2002).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 69.

§ 83-2-5. Filing of rates and related information by residual market mechanisms.

Residual market mechanisms shall file with the commissioner all rates, supplementary rate information, supporting information, policy forms, and endorsements at least thirty (30) days before the proposed effective date. The commissioner may give written notice within thirty (30) days of the receipt of the filing that additional time, not to exceed thirty (30) days from the date of such notice, is necessary to consider the filing. Upon written application by the residual market mechanism, the commissioner may authorize rates to be effective before the expiration of the waiting period or an extension thereof. A filing is deemed to meet the requirements of this chapter and becomes effective unless disapproved by the commissioner before the expiration of the waiting period or an extension thereof. Whenever a filing made under this section is not accompanied by sufficient supporting information, the commissioner shall inform the filing entity as to what information is required to complete the filing. The filing shall not be deemed to be made until such information is furnished.

HISTORY: Laws, 1987, ch. 422, § 4, eff from and after January 1, 1988.

Cross References — Provision that filing may be made by rate service organization instead of insurer, see § 83-2-9.

§ 83-2-7. Filing of rates and related information by insurers; exceptions; effective date of rate adjustment filing; exemption of certain commercial lines insurance coverages from filing and approval requirements.

(1) Except as provided in Section 83-2-9 and subsections (2), (3) and (5) of this section, every insurer shall file with the commissioner all rates, supplementary rate information, policy forms and endorsements at least thirty (30) days prior to the proposed effective date which shall be stated in the filing. Rates, supplementary rate information, policy forms and endorsements need not be filed for inland marine risks which by general custom of the business are not written according to manual rules or rating plans. Upon the request of the commissioner, supporting information shall also be filed. Any filing made under this section is deemed to be approved unless disapproved by the Commissioner of Insurance within thirty (30) days after the date of filing.

(2) A filing of adjustments of rates for existing rating systems made under this section which does not involve a change in the relationship between such rates and the expense portion thereof or does not involve a change of the element of expenses which are paid as a percentage of premiums and does not

involve a change in rate relativities among such classifications on any basis other than loss experience is effective on the date specified in the filing which shall not be less than thirty (30) days after the filing is made and shall be deemed to meet the requirements of this chapter.

(3) The commissioner may give written notice within thirty (30) days of the receipt of the filing that additional time, not to exceed sixty (60) days from the date of such notice, is necessary to consider the filing. A filing is deemed to meet the requirements of this chapter and becomes effective unless disapproved by the commissioner before the expiration of the waiting period or an extension thereof. Whenever a filing made under this section is not accompanied by sufficient supporting information, the commissioner shall inform the filing entity as to what information is required to complete the filing. The filing shall not be deemed to be completed until such information is furnished.

(4) No insurance company shall make or issue a contract or policy except in accordance with filings made with the commissioner, if such filings are required.

(5) Subject to the provisions of subsections (6), (7) and (8) of this section, rates and supplementary rate information for the following commercial lines insurance coverages shall be exempt from filing and approval requirements. However, the rates shall remain subject to the standards set forth in Section 83-2-3. Policy forms and endorsements for the following commercial lines insurance coverages must be filed with the commissioner within sixty (60) days of use for informational purposes only:

(a) Surety and Fidelity;
(b) Boiler and Machinery;
(c) Environmental Impairment or Pollution Liability;
(d) Kidnap and Ransom;
(e) Political Risk or Expropriation;
(f) Excess and Umbrella Liability;
(g) Employment Practices Liability;
(h) Media Liability;
(i) Product Liability, Product Recall, and Completed Operations;
(j) Highly Protected Commercial Property; and
(k) Any other commercial lines insurance coverage or risk that the commissioner shall, pursuant to regulation, exempt from rate, rate supplementary information, or policy form filing requirements in order to promote enhanced competition or to more effectively use the resources of the department that might otherwise be used to review commercial lines filings.

(6) If a commercial lines insurance rate, policy form or endorsement is determined not to comply with the requirements of Mississippi law, the commissioner may issue an order specifying in detail how the rate, policy form, or endorsement fails to meet statutory requirements and further specifying a prospective date after which the rate or form may not be used. The commissioner's findings shall not affect policies in force prior to the date specified in the order. As part of such an order, the commissioner may require the insurer subject to the order to submit a filing for approval by the commissioner of a new rate or policy form, if any, that will replace the discontinued rate or policy form.

(7) The commissioner may temporarily reinstate, for a period of no longer than one (1) year, the filing and approval requirements for rate, rate supplementary information, or policy form for a specific type of commercial lines insurance if, after a hearing, the commissioner makes a finding of fact that a reasonable degree of competition does not exist for that specific type of insurance coverage. Such a finding of fact by the commissioner must specify the relevant tests used to determine whether a lack of a reasonable degree of competition exists and the results thereof. In the absence of such specific findings of fact by the commissioner, it shall be presumed that a competitive market exists.

(8) For purposes of this section, commercial lines insurance means property and casualty insurance for any risk that is not a personal or family risk, but shall not include workers' compensation, medical malpractice liability, creditor-placed insurance or any insurance issued by residual market mechanisms or assigned risk plans.

HISTORY: Laws, 1987, ch. 422, § 5; Laws, 2010, ch. 311, § 1, eff from and after July 1, 2010; Laws, 2020, ch. 447, § 1, eff from and after July 1, 2020.

Cross References — Provisions that filing may be made by rate service organization instead of insurer, and that insurer may make valid filing by giving commissioner written notice of adherence to rates filed by rate service organization, see § 83-2-9.

JUDICIAL DECISIONS

ANALYSIS

1. Anticoncurrent-causation clauses.
2.-5. [Reserved for future use.]
6. Under former § 83-3-107.

1. Anticoncurrent-causation clauses.

Anticoncurrent-causation clause in a homeowners' policy, which stated that the insurer did not cover damage that was caused by both a covered peril and an excluded peril, was valid and enforceable because the clause was unambiguous, the clause had been approved by the Mississippi Department of Insurance pursuant to Miss. Code Ann. § 83-2-7(1) and Miss. Code Ann. § 83-2-11(1)(b), the clause was not forbidden under Mississippi case law or statute, and the clause abrogated the common law rule on efficient proximate causation, which Mississippi had not adopted as a matter of public policy. Leonard v. Nationwide Mut. Ins. Co., 499 F.3d 419, 2007 U.S. App. LEXIS 20947 (5th Cir. Miss. 2007), cert. denied, 552 U.S. 1310, 128 S. Ct. 1873, 170 L. Ed. 2d 745, 2008 U.S. LEXIS 3106 (U.S. 2008).

2.-5. [Reserved for future use.]

6. Under former § 83-3-107.

The insurance commission is vested with the power to require insurance companies to file copies of and information concerning the forms they intend to use in various fire and casualty policies, but Code 1942, §§ 5821 and 5834-03 do not directly confer any power on the commission to approve or disapprove the form of insurance policies as such. Mississippi Ins. Com. v. Mississippi State Rating Bureau, 220 So. 2d 328, 1969 Miss. LEXIS 1456 (Miss. 1969).

§ 83-2-9. Public inspection of filed rates and related information; rates exceeding those filed; filing by rate service organization; filing by reference.

(1) All rates, supplementary rate information, policy forms, endorsements and any supporting information filed under this chapter shall be open to public inspection at any reasonable time as soon as filed. Copies may be obtained by any person on request and upon payment of a reasonable charge.

(2) A rate in excess of that provided by a filing otherwise applicable may be used on a specific risk upon written application of an insured, stating specific reasons why a risk requires higher than standard rates on file by an insurer notwithstanding any other provisions of this chapter. An endorsement shall be attached to the policy giving such reasons and the percentage of surcharge. A copy of the endorsement shall be kept by the insurer and its agent. Copies of such endorsements shall be furnished to the commissioner upon request for his review to determine that the rates are not excessive, inadequate or unfairly discriminatory.

(3) Rate service organization filings:

(a) The filings required by Section 83-2-5 and Section 83-2-7 may be made by a rate service organization designated by an insurer or residual market mechanism.

(b) An insurer may make a filing in compliance with Section 83-2-7 by giving written notice to the commissioner that the insurer is following rates filed by a rate service organization in any particular line with any exceptions clearly set forth as necessary to fully inform the commissioner.

(4) An insurer may file by reference to rates, supplementary rate information, supporting information, policy forms and endorsements filed by and effective for another insurer or a rate service organization.

HISTORY: Laws, 1987, ch. 422, § 6, eff from and after January 1, 1988.

Cross References — Definitions of "advisory organization" and "rate service organization," see § 83-2-1.

Filing requirements concerning rates and related information, see § 83-2-7.

§ 83-2-11. Disapproval of rates by commissioner and related procedure; interim rates in absence of legally effective rates.

(1) The commissioner shall disapprove a rate or policy form or endorsement if the commissioner finds that the rate is unjustified, or the policy form or endorsement:

(a) Is in any respect in violation of or does not comply with this code; or

(b) Contains or incorporates by reference any inconsistent, ambiguous or misleading clauses or exceptions and conditions which unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the contract.

(2) Disapproval procedure:

(a) Upon disapproval of a filing, the commissioner shall issue an order specifying the manner in which the filing fails to meet the requirements of this chapter. The filer shall be given a hearing upon written request made within thirty (30) days after the disapproval order.

(b) If the commissioner disapproves a rate, policy form or endorsement currently in effect, the commissioner shall issue such an order only after a hearing held on not less than twenty (20) days written notice to the filing insurer or rating organization. The insurer or rating organization may waive the hearing. An order shall be issued within fifteen (15) days after the close of the hearing or within thirty (30) days after the filing of a waiver of hearing and shall specify in what respects the rates policy form or endorsement fail to meet the requirements of this chapter. The order shall also state when the further use of such policy form or endorsement or rate in contracts of insurance made thereafter shall be prohibited which shall be within a reasonable period of time, but not less than forty-five (45) days. The order may include a provision for premium adjustment for policies issued, renewed or nonrenewed after the effective date of such order.

(3) Whenever an insurer has no legally effective rates as a result of the commissioner's disapproval of rates or other act, the commissioner on request of the insurer shall specify interim rates for the insurer that are sufficient to protect the interests of all parties and the commissioner may order that a specified portion of the premiums be placed in an escrow account approved by the commissioner. When new rates become legally effective, the commissioner shall order the escrowed funds or any overcharge in the interim rates to be distributed appropriately, except that refunds to policyholders that are de minimis shall not be required.

HISTORY: Laws, 1987, ch. 422, § 7, eff from and after January 1, 1988.

JUDICIAL DECISIONS

ANALYSIS

1. McCarran-Ferguson Act.
2. Anticoncurrent-causation clauses.

1. McCarran-Ferguson Act.
Arbitration of an insurance dispute under the Federal Arbitration Act, 9 U.S.C.S. § 1 et seq., was not reverse-preempted by the McCarran-Ferguson Act because a state insurance policy against mandatory arbitration did not constitute a "state law"; moreover, an informal disapproval did not have any effect because the formal procedures in Miss. Code Ann. § 83-2-11 were not followed. Gulf Ins. Co. v. Neel-Schaffer, Inc., 904 So. 2d 1036, 2004 Miss. LEXIS 1463 (Miss. 2004).

2. Anticoncurrent-causation clauses.
Anticoncurrent-causation clause in a homeowners' policy, which stated that the insurer did not cover damage that was caused by both a covered peril and an excluded peril, was valid and enforceable because the clause was unambiguous, the clause had been approved by the Mississippi Department of Insurance pursuant to Miss. Code Ann. § 83-2-7(1) and Miss. Code Ann. § 83-2-11(1)(b), the clause was not forbidden under Mississippi case law or statute, and the clause abrogated the common law rule on efficient proximate causation, which Mississippi had not adopted as a matter of public policy. Leonard v. Nationwide Mut. Ins. Co., 499 F.3d 419, 2007 U.S. App. LEXIS 20947 (5th Cir.

Miss. 2007), cert. denied, 552 U.S. 1310, 128 S. Ct. 1873, 170 L. Ed. 2d 745, 2008 U.S. LEXIS 3106 (U.S. 2008).

§ 83-2-13. Furnishing rate information to insureds; hearing of complaints as to application of rating system; appeals.

(1) Every insurer or rate service organization shall furnish to any insured affected by a rate published by it all pertinent information as to such rate within a reasonable time after receipt of a written request and upon payment of a reasonable charge.

(2) Every insurer and rate service organization shall provide reasonable means whereby any person aggrieved by the application of its rating system may be heard within this state on written request to review the manner in which such rating system is applied in relation to the insurance afforded. If the insurer fails to grant or reject such request within thirty (30) days, the applicant may proceed in the same manner as if the application has been rejected. A party affected by the action of an insurer with respect to a request under this subsection may appeal to the commissioner within thirty (30) days after receipt of notice of such action. The commissioner, after a hearing held upon not less than ten (10) days written notice to the appellant and insurer, may affirm, modify or reverse such action.

HISTORY: Laws, 1987, ch. 422, § 8, eff from and after January 1, 1988.

§ 83-2-15. Rating bureau as exclusive provider of services relating to rates; licensing of and services provided by rate service organization.

(1) No rate service organization other than the Rating Bureau established pursuant to Section 83-3-5 shall provide any service relating to the rates of any insurance subject to this chapter, and no insurer shall utilize the services of such organization for such purposes unless the organization has obtained a license.

(2) A rate service organization may perform the following services upon request of the Commissioner of Insurance:

(a) Collect, compile and furnish loss or expense statistics;

(b) Recommend rates or supplementary rate information;

(c) Advise about rate questions and provide supporting information for rates;

(d) Make inspections, surveys and audits;

(e) Conduct research and on-site inspections in order to prepare classifications of public fire defenses;

(f) Prepare and file policy forms and endorsements and consult with members, subscribers and others relating to their use;

(g) Provide actuarial, statistical and administrative services to insurers and insurer-supported organizations;

(h) Conduct and report on the content of research projects; and

(i) Furnish any other services related to those enumerated in this subsection.

(3) A rate service organization or an advisory organization shall not refuse to supply any services for which it is licensed in this state to any insurer authorized to do business in this state and offering to pay the fair and usual compensation for the services. A rate service organization shall not require the purchase of any specific services as a condition to obtaining the services sought, provided the furnishing of the requested services does not place an unreasonable burden on the rate service organization.

(4) A rate service organization applying for a license shall include with its application:

(a) A copy of its constitution, articles of association or incorporation, bylaws and any other rules or regulations governing the conduct of its business;

(b) A list of its members and subscribers;

(c) A service and acknowledgement of service of process as provided for insurance companies under Section 83-21-39; and

(d) A statement showing its technical qualifications.

(5) Upon a finding by the commissioner that the applicant is qualified, the commissioner shall issue a license specifying the kinds of insurance or subdivisions thereof for which the applicant is authorized to act as a rate service organization. Each application under this subsection shall be granted or denied in whole or in part by the commissioner within sixty (60) days after the date of its filing. Licenses issued pursuant to this section shall remain in effect until suspended or revoked by the commissioner. The fee for said license shall be Twenty-five Dollars ($25.00).

HISTORY: Laws, 1987, ch. 422, § 9, eff from and after January 1, 1988.

Cross References — Performance of activities enumerated in this section by registered advisory organization, see § 83-2-17.

§ 83-2-17. Advisory organizations; registration; unfair practices.

(1) An advisory organization shall not provide any service relating to the rates of any insurer subject to this chapter, and an insurer shall not utilize the services of an advisory organization for such purposes, unless the advisory organization has registered under subsection (3).

(2) A registered advisory organization may perform one or more of the authorized activities enumerated in Section 83-2-15 but such advisory organization shall not make any filings on behalf of insurers.

(3) An advisory organization shall submit at the time of registration:

(a) A copy of its constitution, articles of association or incorporation, bylaws and any other rules or regulations governing the conduct of its business;

(b) A list of its members and subscribers;

(c) A service and acknowledgement of service of process as provided for insurance companies under Section 83-21-39; and

(d) An agreement that the commissioner may examine each advisory organization in accordance with the provisions of Section 83-2-25.

(4) If after a hearing the commissioner finds that any activity or practice of any advisory organization is unfair, unreasonable or otherwise inconsistent with the provisions of this chapter, the commissioner shall specify the finding in an order requiring the discontinuance of such activity or practice.

HISTORY: Laws, 1987, ch. 422, § 10, eff from and after January 1, 1988.

Cross References — Definition of "advisory organization," see § 83-2-1.

§ 83-2-19. Repealed.

Repealed by Laws, 2000, ch. 314, § 1, eff from and after passage (approved April 3, 2000).

§ 83-2-19. [Laws, 1987, ch. 422, § 11, eff from and after January 1, 1988]

Editor's Notes — Former § 83-2-19 contained provisions requiring each insurer licensed to write property and casualty insurance in Mississippi to annually submit reports of loss and expense experience to the Commissioner of Insurance.

§ 83-2-21. Prohibition of insurer agreements as to adherence to or use of rates and related information; exception for insurers under common ownership or management.

An insurer may not agree with any other insurer to adhere to or use any rate or supplementary rate information. The fact that an insurer adheres to or uses such material is not sufficient in itself to support a finding that an agreement to adhere or use exists, but such fact may supplement other evidence of such agreement. Two (2) or more insurers having common ownership or operating in this state under common management or control may act in concert between or among themselves in the same manner as if they constitute a single insurer.

HISTORY: Laws, 1987, ch. 422, § 12, eff from and after January 1, 1988.

Cross References — Provisions allowing cooperation among insurers participating in joint underwriting, pools or residual mechanisms, with respect to ratemaking and related activity, see § 83-2-23.

§ 83-2-23. Cooperation among insurers participating in joint underwriting, pools, residual market mechanisms; registration with and review by commissioner; unfair practices.

(1) Notwithstanding Section 83-2-21, insurers participating in joint underwriting, pools or residual market mechanisms may act in cooperation with each other in the making of rates, supplementary rate information, policy forms, underwriting rules, surveys, inspections and investigations, the furnishing of loss or expense statistics or other such information and in the conduct of research in connection with such activity.

(2)(a) Except to the extent modified by this section, insurers participating in joint underwriting, pool or residual market mechanisms are subject to the other provisions of this chapter.

(b) Every pool shall file with the commissioner a copy of its constitution, articles of association or incorporation, bylaws and any other rules or regulations governing its activities, a list of its members, the name and address of a resident of this state upon whom notices or orders of the commissioner or process may be served, and any changes in the foregoing.

(c) Any residual market mechanism, plan or agreement to implement such a mechanism, and any amendments thereto, shall be submitted in writing to the commissioner for approval, together with such information as the commissioner may reasonably require.

(d) If, after a hearing, the commissioner finds that any activity or practice of insurers participating in joint underwriting, pool or residual market mechanisms is unfair, unreasonable or otherwise inconsistent with the provisions of this chapter, the commissioner shall issue a written order specifying in what respects such activity or practice is unfair, unreasonable or otherwise inconsistent with the provisions of this chapter and require the discontinuance of such activity or practice.

HISTORY: Laws, 1987, ch. 422, § 13, eff from and after January 1, 1988.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 69.

§ 83-2-25. Compliance review; related reports and records.

(1) The commissioner may examine any insurer, advisory organization, rate service organization, pool or residual market mechanism to ascertain compliance with this chapter.

(2) Every insurer, advisory organization, rate service organization, pool and residual market mechanism shall maintain records of the type and kind reasonably adapted to its method of operation. Such records shall contain the experience, data, statistics and other information collected or used by it in its activities. These records shall be available for examination or inspection by the commissioner at any time upon reasonable notice.

(3) The cost of an examination made pursuant to this section shall be paid by the examined party in the same manner as provided by Section 83-1-27.

(4) The commissioner may accept the report of an examination made by the insurance supervisory official of another state in lieu of an examination under this section.

HISTORY: Laws, 1987, ch. 422, § 14, eff from and after January 1, 1988.

§ 83-2-27. Payment of dividends, savings or unabsorbed premium deposits to insureds.

Nothing in this chapter shall be construed to prohibit or regulate the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers. A plan for the payment of dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers shall not be deemed a rating plan.

HISTORY: Laws, 1987, ch. 422, § 15, eff from and after January 1, 1988.

§ 83-2-29. Penalties; procedures for license suspension.

(1) If the commissioner finds that any person or organization has violated any provision of this chapter, the commissioner may impose a penalty in accordance with Section 83-5-85. Technical violations arising from systems or computer errors of the same type shall be treated as a single violation. In the event of an overcharge, if the insurer makes restitution, including payment of interest, no penalty shall be imposed.

(2) The commissioner, within his discretion, is authorized to abate such part of the foregoing penalty as the facts of the particular case warrant and to bring suit for such lesser amount as may be determined, or to accept such lesser amount in settlement of the state's claim for penalties.

(3) The commissioner may suspend the license of any rate service organization or insurer for failure to comply with an order of the commissioner within the time limit set forth in the order, or any extension thereof which the commissioner may grant. The commissioner may determine when a suspension of license shall become effective and it shall remain in effect for the stated period unless modified or rescinded by the commissioner until the order upon which the suspension is based is modified, rescinded or reversed.

(4) A license shall not be suspended except upon a written order of the commissioner stating his findings, made after a hearing held upon not less than ten (10) days written notice to such person or organization, specifying the alleged violation.

HISTORY: Laws, 1987, ch. 422, § 16, eff from and after January 1, 1988.

JUDICIAL DECISIONS

ANALYSIS

1. Enforcement.
2.-5. [Reserved for future use.]
6. Under former § 83-3-37.

1. Enforcement.

Miss. Code Ann. § 83-2-3 was regulatory in nature and afforded no private right of action; the Mississippi Commissioner of Insurance was charged with enforcement of § 83-2-3. Miss. Code Ann. § 83-2-29(1). The defendant correctly stated that the plaintiff confessed the excessive rate standards claim, and the parties agreed that no private cause of action existed under Miss. Code Ann. § 83-2-3; therefore, the court granted summary judgment in favor of the defendant as to the plaintiff's excessive rate standards claim. Mullen v. Nationwide Mut. Ins. Co., 2013 U.S. Dist. LEXIS 7679 (S.D. Miss. Jan. 18, 2013).

2.-5. [Reserved for future use.]

6. Under former § 83-3-37.

Contract by which insurance agent induced insured to take out policies by making payment about amount of premium on past-due note owing by third party to insured, being in violation of statute forbidding special inducements in making of insurance contracts, insured held not entitled to recover from insurance companies premiums paid under policies later canceled, which premiums had never been forwarded by agent to insurance companies, on ground that parties to an illegal contract should not recover money paid under contract. City of New York Ins. Co. v. Greenwood International Co., 170 Miss. 644, 155 So. 346, 1934 Miss. LEXIS 167 (Miss. 1934).

§ 83-2-31. Appeals; rates charged pending disposition of appeal.

Any order issued by the commissioner under this chapter may be appealed to the Chancery Court of the First Judicial District of Hinds County in the manner provided by law. Where the order of the commissioner results in an increase or decrease in rates, any insurer affected thereby with leave of court, pending final disposition of the proceedings in the court, may continue to charge rates which were obtained prior to such order of decrease, or may charge rates resulting from such order of increase on condition that the difference in the premiums be deposited in a special account by the insurer or paid to the holders of policies issued after the order of the commissioner, as the court may determine.

HISTORY: Laws, 1987, ch. 422, § 17, eff from and after January 1, 1988.

§ 83-2-33. Property and casualty insurance companies to contribute to Insurance Department Fund; funding of agency expenses; deposit of monies into State General Fund.

All property and casualty insurance companies doing business in this state shall contribute annually, at such times as the Insurance Commissioner shall determine, in proportion to their gross premiums collected within the State of Mississippi during the preceding year, to a special fund in the State Treasury to be known as the "Insurance Department Fund" to be expended by the Insurance Commissioner in the payment of the expenses of the Department of Insurance as the commissioner may deem necessary. The commissioner is hereby authorized to employ such actuarial and other assistance as shall be necessary to carry out the duties of the department; and such employees shall be under the authority and direction of the Insurance Commissioner. The amount to be contributed annually to the fund shall be fixed each year by the Insurance Commissioner at a percentage of the gross premiums so collected during the preceding year. However, a minimum assessment of One Hundred Dollars ($100.00) shall be charged to each licensed property and casualty insurance company regardless of the gross premium amount collected during the preceding year.

The total contributions collected for the Insurance Department Fund shall not exceed the sum of Seven Hundred Fifty Thousand Dollars ($750,000.00) in each fiscal year.

From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Laws, 1987, ch. 422, § 55; Laws, 1990, ch. 557, § 3; Laws, 1991, ch. 430 § 3; Laws, 1998, ch. 451, § 1; Laws, 2016, ch. 459, § 19, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Payment of filing fee by property and casualty insurers to be deposited into Insurance Department Fund, see § 83-2-35.

Contributions of life, health and accident insurance companies to Insurance Department Fund, see § 83-5-72.

Requirement that the department deposit all sums collected from home warranty associations for failing to timely file its annual statement to the credit of the Insurance Department Fund, see § 83-57-27.

§ 83-2-35. Payment of fee by property and casualty insurers; deposit of fee into Insurance Department Fund; funding of agency expenses; deposit of monies into State General Fund.

(1) This section applies to all forms of property and casualty insurance on risks or operations in this state by any insurer authorized to do business in this state, except:

(a) Accident and health;
(b) Ocean marine insurance;
(c) Reinsurance;
(d) Aircraft liability and aircraft hull insurance;
(e) Title insurance;
(f) Credit accident and health insurance.

(2) All such insurers shall pay to the Commissioner of Insurance a fee of Fifteen Dollars ($15.00) for each form or rate filing filed with the commissioner.

The commissioner shall pay such fees into the special fund in the State Treasury designated as the "Insurance Department Fund."

(3) From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

(4) From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Laws, 1991, ch. 467 § 1; Laws, 2016, ch. 459, § 20, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

CHAPTER 3.

COMMISSIONER OF INSURANCE, RATING BUREAU AND RATES

Article 1.	Commissioner of Insurance and Rating Bureau.	83-3-1
Article 3.	Casualty Insurance Rates.	83-3-101
Article 5.	Advisory Organizations. [Repealed].	83-3-201
Article 7.	Agency Review. [Repealed].	83-3-301

ARTICLE 1.

COMMISSIONER OF INSURANCE AND RATING BUREAU.

Sec.	
83-3-1.	Repealed.
83-3-2.	Meaning of "Insurance Commission."
83-3-3.	Repealed.
83-3-5.	Rating bureau.
83-3-7.	Members of bureau.
83-3-9.	Expense of bureau paid by companies.
83-3-11.	Funds provided by assessment against companies.
83-3-13.	Bureau to inspect every risk rated.
83-3-15.	Repealed.
83-3-17.	Bureau not to make agreement for placing insurance.
83-3-19.	Rating Bureau to furnish information to Commissioner of Insurance.
83-3-21.	Examination of Rating Bureau; reports.
83-3-23.	Bureau not to discriminate in rates.
83-3-24.	Factors to be considered when rating fire district, grading fire departments and awarding credits considered in determining overall fire rating based on condition of certain fire equipment.
83-3-25 through 83-3-41.	Repealed.

§ 83-3-1. Repealed.

Repealed by Laws, 1987, ch. 422, § 30, eff from and after January 15, 1988.

§ 83-3-1. [Codes, 1930, § 5302; 1942, § 5816; Laws, 1924, ch. 188; Laws, 1935, Ex. ch 34; Laws, 1966, ch. 445, § 13; Laws, 1977, ch. 303; Laws, 1978, ch. 520, § 15; reenacted and amended, Laws, 1982, ch. 487, § 1]

Editor's Notes — Former § 83-3-1 provided for the creation of the Insurance Commission. See § 83-3-2 which provides that any reference to Insurance Commission in Title 83 shall mean the Commissioner of Insurance.

§ 83-3-2. Meaning of "Insurance Commission."

Any reference to Insurance Commission in Title 83 shall mean the Commissioner of Insurance.

HISTORY: Laws, 1987, ch. 422, § 29; reenacted, Laws, 1991, ch. 317, § 1; reenacted without change, Laws, 1998, ch. 456, § 1, eff from and after July 1, 1998.

§ 83-3-3. Repealed.

Repealed by Laws of 1987, ch. 422, § 30, eff from and after January 1, 1988.

§ 83-3-3. [Codes, 1930, § 5302; 1942, § 5816; Laws, 1924, ch. 188; Laws, 1935, Ex. ch. 34; Laws, 1966, ch. 445, § 13; reenacted without change, Laws, 1982, ch. 487, § 2]

Editor's Notes — Former § 83-3-3 pertained to the approval of rate schedules.

§ 83-3-5. Rating bureau.

All fire insurance companies organized or admitted to do business in this state shall maintain a Rating Bureau, to be composed of such number of persons resident in this state as shall be desired and who shall be skilled in the business of fire insurance rating, fire hazard, fire protection engineering, and fire insurance inspection. Said Rating Bureau may be chartered or operated as a corporation, or association, or limited partnership, and shall provide for such officers, board of directors, and bylaws as it may deem proper, and change or alter the same from time to time as may be necessary. The Rating Bureau shall maintain an office in the Jackson metropolitan area; and all of the correspondence, files, papers, and documents of such Rating Bureau shall be preserved by said bureau, and shall be opened at all times to the inspection and examination of any insured or any person interested.

HISTORY: Codes, 1930, § 5303; 1942, § 5817; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 3; Laws, 1987, ch. 422, § 18; reenacted, Laws, 1991, ch. 317, § 2; reenacted without change, Laws, 1998, ch. 456, § 2, eff from and after July 1, 1998.

Cross References — State rating bureau's manager's membership on the state fire academy advisory board, see § 45-11-8.

Provision of rate services by Rating Bureau only, see § 83-2-15.

JUDICIAL DECISIONS

ANALYSIS

1.-5. [Reserved for future use.]
6. Under former § 83-3-29.

1.-5. [Reserved for future use.]

6. Under former § 83-3-29.

The Casualty Rating Law of 1946 does not operate to amend or repeal pro tanto the Fire Rating Law of 1924, but both must be construed together so as to reconcile and give full effect to all provisions in both where reasonably possible. Insurance Co. of North America v. Insurance Com. of State, 237 Miss. 759, 116 So. 2d 224, 1959 Miss. LEXIS 529 (Miss. 1959).

Federal antitrust laws may not be invoked against the fixing of fire insurance rates by a state commission upon the report and recommendation of a rating bureau of which stock fire insurance companies are members. Insurance Co. of North America v. Insurance Com. of State, 237 Miss. 759, 116 So. 2d 224, 1959 Miss. LEXIS 529 (Miss. 1959).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 73.

CJS.
44 C.J.S., Insurance §§ 81-83.

§ 83-3-7. Members of bureau.

Each fire insurance company licensed to do business in this state shall become a member of the Rating Bureau and shall pay its proportion of the expenses of organization, maintenance, and operation of said bureau, as provided in Section 83-3-9.

HISTORY: Codes, 1930, § 5312; 1942, § 5826; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 4; Laws, 1987, ch. 422, § 19; reenacted, Laws, 1991, ch. 317, § 3; reenacted without change, Laws, 1998, ch. 456, § 3, eff from and after July 1, 1998.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 73.

CJS.
44 C.J.S., Insurance §§ 81-83.

§ 83-3-9. Expense of bureau paid by companies.

The expense of the organization, maintenance, and operation of the Rating Bureau shall be paid by the members of the bureau, and no part of said expense shall in any event be paid by the state or by any county or municipality. The expense not covered by user fees shall be shared by all members through an annual assessment as established by the board of directors with due consideration given to the extent of utilization of bureau services. Upon failure of any company to pay its lawful proportion of said expense within thirty (30) days after the same is due and payable, the Rating Bureau may refuse to furnish its service to such delinquent member, and shall report such delinquency to the Commissioner of Insurance, who for such delinquency may suspend or revoke the license of such delinquent company. The bureau shall establish equitable fees for its services sufficient to cover the operations required under Section 83-2-1 et seq.

HISTORY: Codes, 1930, § 5314; 1942, § 5828; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 5; Laws, 1987, ch. 422, § 20; reenacted, Laws, 1991, ch. 317, § 4; reenacted without change, Laws, 1998, ch. 456, § 4, eff from and after July 1, 1998.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 73.
14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.
44 C.J.S., Insurance §§ 81-83.

§ 83-3-11. Funds provided by assessment against companies.

It shall be the duty of the Rating Bureau to provide a fund sufficient to enable it to inspect every risk specifically rated, to make a written survey of such risks, to pay the salary or expense of its officers and employees, and to cover any other expense which may be necessary or proper to enable it to comply with and enforce the provisions of this article. All of the expense fund shall be provided and paid by the fire insurance companies doing business in this state.

HISTORY: Codes, 1930, § 5318; 1942, § 5832; Laws, 1924, ch. 188; Laws, 1935, Ex. ch. 34; Laws, 1962, ch. 467; reenacted without change, Laws, 1982, ch. 487, § 6; Laws, 1987, ch. 422, § 21; reenacted, Laws, 1991, ch. 317, § 5; reenacted without change, Laws, 1998, ch. 456, § 5, eff from and after July 1, 1998.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 73.	44 C.J.S., Insurance §§ 81-83.

§ 83-3-13. Bureau to inspect every risk rated.

The Rating Bureau, through its members and employees, shall inspect every risk specifically rated by it on schedule, and make a written survey of such risk, which shall be filed as a permanent record in such Rating Bureau. A copy of such survey shall be furnished to the owner, other person in interest, or the Commissioner of Insurance upon request.

HISTORY: Codes, 1930, § 5304; 1942, § 5818; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 7; Laws, 1987, ch. 422, § 22; reenacted, Laws, 1991, ch. 317, § 6; reenacted without change, Laws, 1998, ch. 456, § 6, eff from and after July 1, 1998.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 73.	44 C.J.S., Insurance §§ 81-83.

§ 83-3-15. Repealed.

Repealed by Laws of 1987, ch. 422, § 30, eff from and after January 1, 1988.

§ 83-3-15. [Codes, 1930, § 5305; 1942, § 5819; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 8]

Editor's Notes — Former § 83-3-15 required schedule changes be submitted to the insurance commission.

§ 83-3-17. Bureau not to make agreement for placing insurance.

The rating bureau, or any of its officers, shall not make any contract or agreement, express or implied, with any person, insurer, or party insured, that the whole, or any part, of the insurance shall be written or placed with any particular insurer.

HISTORY: Codes, 1930, § 5306; 1942, § 5820; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 9; reenacted without change, Laws, 1991, ch. 317, § 7; reenacted without change, Laws, 1998, ch. 456, § 7, eff from and after July 1, 1998.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 73.

CJS.
44 C.J.S., Insurance §§ 81-83.

§ 83-3-19. Rating Bureau to furnish information to Commissioner of Insurance.

The Rating Bureau is required to answer any inquiries that may be made by the Commissioner of Insurance touching its organization, maintenance, operation, or any other matter connected with its transactions; and said commissioner may require the filing of such other information as the commissioner may deem proper. It shall be the duty of such bureau to promptly make reply to such inquiries, in writing, and to furnish the information requested by the Commissioner of Insurance.

HISTORY: Codes, 1930, § 5307; 1942, § 5821; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 10; Laws, 1987, ch. 422, § 23; reenacted, Laws, 1991, ch. 317, § 8; reenacted without change, Laws, 1998, ch. 456, § 8, eff from and after July 1, 1998.

JUDICIAL DECISIONS

1. In general.
The insurance commission is vested with the power to require insurance companies to file copies of and information concerning the forms they intend to use in various fire and casualty policies, but Code 1942, §§ 5821 and 5834-03 do not directly confer any power on the commission to approve or disapprove the form of insurance policies as such. Mississippi Ins. Com. v. Mississippi State Rating Bureau, 220 So. 2d 328, 1969 Miss. LEXIS 1456 (Miss. 1969).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 73.

CJS.
44 C.J.S., Insurance §§ 81-83.

§ 83-3-21. Examination of Rating Bureau; reports.

The Commissioner of Insurance shall have the power to examine the Rating Bureau as often as he deems expedient, at the expense of the bureau. The commissioner shall report his findings in writing, which shall be filed in his office and made a part of the annual report of his office; and a copy thereof shall be filed with the Attorney General for the information of the legal department of the state.

HISTORY: Codes, 1930, § 5308; 1942, § 5822; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 11; Laws, 1987, ch. 422, § 24; reenacted, Laws, 1991, ch. 317, § 9; reenacted without change, Laws, 1998, ch. 456, § 9, eff from and after July 1, 1998.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 73.

CJS.
44 C.J.S., Insurance §§ 81-83.

§ 83-3-23. Bureau not to discriminate in rates.

The Rating Bureau shall not recommend any rate for insurance upon property in this state which discriminates unfairly in the same territorial classification between risks in the application of like charges and credits, or which discriminates unfairly between risks of essentially the same hazard and having substantially the same degree of protection against fire.

HISTORY: Codes, 1930, § 5309; 1942, § 5823; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 12; Laws, 1987, ch. 422, § 25; reenacted, Laws, 1991, ch. 317, § 10; reenacted without change, Laws, 1998, ch. 456, § 10, eff from and after July 1, 1998.

Cross References — Discrimination in casualty insurance rates, see § 83-3-121.

JUDICIAL DECISIONS

1. In general.

Federal antitrust laws may not be invoked against the fixing of fire insurance rates by a state commission upon the report and recommendation of a rating bureau of which stock fire insurance companies are members. Insurance Co. of North America v. Insurance Com. of State, 237 Miss. 759, 116 So. 2d 224, 1959 Miss. LEXIS 529 (Miss. 1959).

The Casualty Rating Law of 1946 does not operate to amend or repeal pro tanto the Fire Rating Law of 1924, but both must be construed together so as to reconcile and give full effect to all provisions in both where reasonably possible. Insurance Co. of North America v. Insurance Com. of State, 237 Miss. 759, 116 So. 2d 224, 1959 Miss. LEXIS 529 (Miss. 1959).

Under this provision loss experience is not a criterion for fixing fire premium rates. Insurance Co. of North America v. Insurance Com. of State, 237 Miss. 759, 116 So. 2d 224, 1959 Miss. LEXIS 529 (Miss. 1959).

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 73.	44 C.J.S., Insurance §§ 81-83.

§ 83-3-24. Factors to be considered when rating fire district, grading fire departments and awarding credits considered in determining overall fire rating based on condition of certain fire equipment.

(1) When rating a municipality or fire district, including evaluations of rural or volunteer fire departments, the Rating Bureau shall consider the mileage, condition and maintenance of the fire trucks rather than the age of the fire trucks. For the purpose of grading municipalities or fire districts, including rural and volunteer fire departments, and awarding credits that are considered in determining an overall fire rating based upon the condition of their fire trucks, the Rating Bureau shall publish guidelines for use in the grading of fire trucks not later than January 30 of the calendar year during which the Rating Bureau will apply the guidelines. These guidelines shall be published and made available to each municipality and fire district, including rural and volunteer fire departments, on the Rating Bureau's website not later than January 30 of the calendar year during which the Rating Bureau will apply the guidelines. If a fire truck in a municipality or fire district, including rural and volunteer fire departments, satisfies the guidelines, then the Rating Bureau shall not recommend the replacement of the fire truck before the next grading process.

(2) For the purpose of grading fire departments, the alternative water supply standard shall be two hundred fifty (250) gallons per minute for a sustained period of one (1) hour.

HISTORY: Laws, 1988, ch. 529; reenacted, Laws, 1991, ch. 317, § 11; reenacted without change, Laws, 1998, ch. 456, § 11; Laws, 2011, ch. 486, § 1, eff from and after July 1, 2011.

Cross References — State agencies and public officials providing information about the agency or office to the public on a website are required to regularly review and update that information, see § 25-1-117.

§§ 83-3-25 through 83-3-41. Repealed.

Repealed by Laws 1987, ch. 422, § 30, eff from and after January 1, 1988.

§ 83-3-25. [Codes, 1930, § 5310; 1942, § 5824; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 13]

§ 83-3-27. [Codes, 1930, § 5311; 1942, § 5825; Laws, 1924, ch. 188; Laws, 1938, ch. 196; Laws, 1962, ch. 471; reenacted without change, Laws, 1982, ch. 487, § 14]

§ 83-3-29. [Codes, 1930, § 5311; 1942, § 5825; Laws, 1924, ch. 188; Laws, 1938, ch. 196; Laws, 1962, ch. 471; reenacted without change, Laws, 1982, ch. 487, § 15]

§ 83-3-31. [Codes, 1930, § 5313; 1942, § 5827; Laws, 1924, ch. 188; Laws, 1962, ch. 472; reenacted without change, Laws, 1982, ch. 487, § 16]

§ 83-3-33. [Codes, 1930, § 5319; 1942, § 5833; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 17]

§ 83-3-35. [Codes, 1930, § 5315; 1942, § 5829; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 18]

§ 83-3-37. [Codes, 1930, § 5316; 1942, § 5830; Laws, 1924, ch. 188; reenacted without change, Laws 1982, ch. 487, § 19]

§ 83-3-39. [Codes, 1930, § 5317; 1942, § 5831; Laws, 1924, ch. 188; reenacted without change, Laws, 1982, ch. 487, § 20]

§ 83-3-41. [Codes, 1930, § 5320; 1942, § 5834; Laws, 1924, ch. 188; Laws, 1946, ch. 354, § 1; reenacted without change, Laws, 1982, ch. 487, § 21]

Editor's Notes — Former § 83-3-25 provided that the insurance commission was to hear discrimination complaints.

Former § 83-3-27 required insurers to submit statistical reports.

Former § 83-3-29 required the adjustment of rates if profits or losses were excessive.

Former § 83-3-31 permitted insurers to file an application for uniform percentage deviation from class rates.

Former § 83-3-33 authorized the revocation of a fire insurance company's license to do business for allowing forbidden inducements.

Former § 83-3-35 permitted appeals by certiorari to chancery courts.

Former § 83-3-37 provided for penalties for violations of provisions of Chapter 1 of Title 83.

Former § 83-3-39 provided that the provisions of Chapter 1 of Title 83 were not applicable to railroad corporations or other common carriers.

Former § 83-3-41 provided that Chapter 1 of Title 83 was not applicable to any mutual insurance company or reciprocal or inter-insurance exchange.

ARTICLE 3.

CASUALTY INSURANCE RATES.

Sec.
83-3-101 through 83-3-119. Repealed.
83-3-121. Rebates prohibited.
83-3-123 through 83-3-129. Repealed.

§§ 83-3-101 through 83-3-119. Repealed.

Repealed by Laws, 1987, ch. 422, § 31, eff from and after January 1, 1988.

§ 83-3-101. [Codes, 1942, § 5834-01; Laws, 1946, ch. 356, § 1; Laws, 1948, ch. 351, § 1; reenacted without change, Laws, 1982, ch. 487, § 22]

§ 83-3-103. [Codes, 1942, § 5834-01; Laws, 1946, ch. 356, § 1; Laws, 1948, ch. 351, § 1; reenacted without change, Laws, 1982, ch. 487, § 23]

§ 83-3-105. [Codes, 1942, § 5834-02; Laws, 1946, ch. 356, § 2; reenacted without change, Laws, 1982, ch. 487, § 24]

§ 83-3-107. [Codes, 1942, § 5834-03; Laws, 1946, ch. 356, § 3; reenacted without change, Laws, 1982, ch. 487, § 25]

§ 83-3-109. [Codes, 1942, § 5834-04; Laws, 1946, ch. 356, § 4; reenacted without change, Laws, 1982, ch. 487, § 26]

§ 83-3-111. [Codes, 1942, § 5834-05; Laws, 1946, ch. 356, § 5; Laws, 1962, ch. 468; Laws, 1971, ch. 392, § 1; Laws, 1979, ch. 416, § 1; Laws, 1978, ch. 424, § 1; Laws, 1980, ch. 376; reenacted, Laws, 1982, ch. 487, § 27]

§ 83-3-113. [Codes, 1942, § 5834-06; Laws, 1946, ch. 356, § 6; reenacted without change, Laws, 1982, ch. 487, § 28]

§ 83-3-115. [Codes, 1942, § 5834-07; Laws, 1946, ch. 356, § 7; reenacted without change, Laws, 1982, ch. 487, § 29]

§ 83-3-117. [Codes, 1942, § 5834-07; Laws, 1946, ch. 356, § 7; reenacted without change, Laws, 1982, ch. 487, § 30]

§ 83-3-119. [Codes, 1942, § 5834-08; Laws, 1946, ch. 356, § 8; reenacted without change, Laws, 1982, ch. 487, § 31]

Editor's Notes — Former § 83-3-101 stipulated the purpose of Article 1 of Chapter 3 of Title 83.

Former § 83-3-103 contained definitions applicable to casualty insurance.

Former § 83-3-105 provided for making of casualty insurance rates.

Former § 83-3-107 pertained to filing of rates and rating information.

Former § 83-3-109 provided for rating organizations.

Former § 83-3-111 established the insurance commission fund.

Former § 83-3-113 authorized a rating organization to file application to deviate from established rates.

Former § 83-3-115 pertained to recording and reporting loss and expense experiences.

Former § 83-3-117 authorized the insurance commission to promulgate rules and regulations.

Former § 83-3-119 prohibited the dissemination of false or misleading information.

§ 83-3-121. Rebates prohibited.

No insurance company, or employee thereof, and no broker or agent shall knowingly charge, demand, or receive a premium for any policy of insurance except in accordance with the applicable filing approved in the manner herein provided. No such insurer or employee or agent thereof shall pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, as an inducement to insurance or after insurance has been affected, any rebate, discount, abatement, credit, or reduction of the premium named in a policy of insurance, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever, not specified in the policy of insurance. No insured named in a policy of insurance nor any employee of such insured shall knowingly receive or accept, directly or indirectly, any such rebate, discount, abatement, or reduction of premium, or any special favor or advantage or valuable consideration or inducement. Nothing herein contained shall be construed as prohibiting the payment of commissions or other compensation to duly licensed agents, nor as prohibiting any participating insurer from distributing to its policyholders dividends, savings, or the unused or unabsorbed portion of premiums or premium deposits nor as prohibiting any duly licensed agent from advancing an insurance premium for the insured with or without interest thereon subject to the rules and regulations of the Mississippi Department of Insurance.

HISTORY: Codes, 1942, § 5834-09; Laws, 1946, ch. 356, § 9; reenacted without change, Laws, 1982, ch. 487, § 32; Laws, 1987, ch. 422, § 27; reenacted, Laws, 1991, ch. 317, § 12; reenacted without change, Laws, 1998, ch. 456, § 12; Laws, 2000, ch. 377, § 1, eff from and after July 1, 2000.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2.-5. [Reserved for future use.]
6. Under former § 83-3-33.

1. In general.

The Commissioner of Insurance improperly denied an application of a farmers' production credit association for an incorporated insurance agency license, where there was no proof that the association would allow rebates, discounts, or other inducements to purchase insurance, as prohibited by this section and § 83-3-33; although income derived from the sale of the policies would contribute to net earnings, distribution of net earnings to the association's stockholders would not violate these sections. Commissioner of Ins. v. Jackson Production Credit Asso., 377 So. 2d 1047, 1979 Miss. LEXIS 2518 (Miss. 1979).

2.-5. [Reserved for future use.]

6. Under former § 83-3-33.

Purpose of statute forbidding special inducements in making of insurance contracts was to subserve a public policy intended to promote solvency of insurance companies, to give equal opportunity in cost of insurance to those engaged in business, and to assure equality of opportunity and privilege to all local insurance agents. City of New York Ins. Co. v. Greenwood International Co., 170 Miss. 644, 155 So. 346, 1934 Miss. LEXIS 167 (Miss. 1934).

Contract of insurance being in violation of statute forbidding special inducements, insured held not entitled to recover premiums paid on policies, later canceled, which premiums had not been forwarded to insurance company by agent, on ground parties to illegal contract should not be permitted to recover money paid under the contract. City of New York Ins. Co. v. Greenwood International Co., 170 Miss. 644, 155 So. 346, 1934 Miss. LEXIS 167 (Miss. 1934).

OPINIONS OF THE ATTORNEY GENERAL

The statute does not permit an insurance agent to pay an insurance premium for a client and then bill the client for the premium paid plus any finance charges for amounts that are past due to the agent. Dale, Nov. 12, 1999, A.G. Op. #99-0615.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 537, 538.

CJS.

44 C.J.S., Insurance §§ 551, 552.

§§ 83-3-123 through 83-3-129. Repealed.

Repealed by Laws, 1987, ch. 422, § 31, eff from and after January 1, 1988.

§ 83-3-123. [Codes, 1942, § 5834-10; Laws, 1946, ch. 356, § 10; reenacted without change, Laws, 1982, ch. 487, § 33]

§ 83-3-125. [Codes, 1942, § 5834-10; Laws, 1946, ch. 356, § 10; reenacted without change, Laws, 1982, ch. 487, § 34]

§ 83-3-127. [Codes, 1942, § 5834-11; Laws, 1946, ch. 356, § 11; reenacted without change, Laws, 1982, ch. 487, § 35]

§ 83-3-129. [Codes, 1942, § 5834-13; Laws, 1946, ch. 356, § 13; reenacted without change, Laws, 1982, ch. 487, § 36]

Editor's Notes — Former § 83-3-123 authorized the insurance commission to conduct hearings on grievances.

Former § 83-3-125 authorized appeals from final decisions or orders of the insurance commission.

Former § 83-3-127 provided for penalties for violations of Article 3 of Chapter 3 of Title 83.

Former § 83-3-129 excepted existing insurance contracts from the provisions of Article 3 of Chapter 3 of Title 83.

ARTICLE 5.

ADVISORY ORGANIZATIONS [REPEALED].

Sec.
83-3-201 through 83-3-207. Repealed.

§§ 83-3-201 through 83-3-207. Repealed.

Repealed by Laws 1987, ch. 422, § 32, eff from and after January 1, 1988.

§§ 83-3-201 through § 83-3-207. [5649-21; Laws, 1958, ch. 444, §§ 1-4; reenacted without change, Laws, 1982, ch. 487, §§ 37-40]

ARTICLE 7.

AGENCY REVIEW [REPEALED].

Sec.
83-3-301. Repealed.

§ 83-3-301. Repealed.

Repealed by Laws 1998, ch. 456, § 13, eff from and after July 1, 1998.

§ 83-3-301. [Laws, 1979, ch. 301, § 46; Laws, 1982, ch. 487, § 41; Laws, 1990, ch. 575, § 1; Laws, 1991, ch. 317, § 13, eff from and after July 1, 1991]

Editor's Notes — Former Section 83-3-301 provided for the repeal of §§ 83-3-2 through 83-3-24 and 83-3-121 as of December 31, 1999.

CHAPTER 5.

GENERAL PROVISIONS RELATIVE TO INSURANCE AND INSURANCE COMPANIES

Article 1. General Provisions. 83-5-1
Article 2. Audit of Financial Statements of Insurers. 83-5-101
Article 3. Periodic Financial Examinations of Insurers. 83-5-201
Article 4. "Insurable Interest" Requirements. 83-5-251
Article 5. Filing Copy of Annual Statement With National Association of Insurance Commissioners; Generation of Reports. .. 83-5-301
Article 6. Disclosure of Material Acquisitions, Dispositions of Assets, and Reinsurance Agreements. 83-5-351
Article 7. Risk-Based Capital Level Requirements. 83-5-401
Article 8. Property and Casualty Actuarial Opinion Act. 83-5-501
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Article 10. Corporate Governance Annual Disclosures. 83-5-701
Article 11. Insurance Data Security Law. 83-5-801
Article 13. Mississippi Insurance E-Commerce Model Act. 83-5-851

ARTICLE 1.

GENERAL PROVISIONS.

Sec.

83-5-1. Concerns subject to department.
83-5-3. All companies to submit to all laws of state.
83-5-5. Terms defined.
83-5-7. Situs of contract.
83-5-9. Business to be conducted in corporate name.
83-5-11. Legal process.
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83-5-17. Revocation of license; administrative fine; funding of agency expenses; deposit of monies into State General Fund.
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83-5-29. Insurance business practices regulated.
83-5-30. Insurance business practices regulated; notice of withdrawal, cancelation, or failure to renew insurance; penalties.
83-5-31. Insurance business practices regulated; definitions.
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83-5-37. Insurance business practices regulated; power of commissioner.

Sec.
83-5-39. Insurance business practices regulated; hearings on charges of unfair practices.
83-5-41. Insurance business practices regulated; cease and desist orders and modifications thereof; administrative fines; funding of agency expenses; deposit of monies into State General Fund.
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§ 83-5-1. Concerns subject to department.

All indemnity or guaranty companies, all companies, including those companies defined in Section 83-41-303(n), corporations, partnerships, associations, individuals and fraternal orders, whether domestic or foreign, transacting, or to be admitted to transact, the business of insurance in this state are insurance companies within the meaning of this chapter, and shall be subject to the inspection and supervision of the commissioner.

HISTORY: Codes, 1857, ch. 35, art. 60; 1871, § 2445; 1880, § 1076; 1892, § 2326; 1906, § 2559; Hemingway's 1917, § 5023; 1930, § 5129; 1942, § 5631; Laws, 1910, ch. 103; Laws, 1997, ch. 410, § 2, eff from and after July 1, 1997.

Cross References — Hospital trust to insure against public liability claims not being subject to supervision of insurance commissioner, see § 41-13-107.

Application of definition of "Insurer" in this section to periodic financial examinations of insurers, see § 83-5-203.

Registration and examination of companies writing casualty insurance, ordinary life insurance or health and accident insurance, see §§ 83-6-1 et seq.

Exclusion of burial associations regulated under §§ 83-37-1 et seq. from definition of "insurer" as provided in this section, see § 83-6-1.

Application of definition of "Insurer" in this section to Managing General Agents Act, see § 83-18-103.

Classes of insurance companies, see § 83-19-1.

Exclusion of nonprofit dental service corporations from insurance laws, see § 83-43-7.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. What constitutes business of insurance.

1. In general.

Duty and responsibility of the commissioner of insurance is prescribed primarily for the protection of the policyholders and the public, and the sections relating thereto were not intended to deal with the relation existing between the insurance corporation and its stockholders, or to require the commissioner to concern himself with the internal affairs and details of operation or management. Sanders v. Neely, 197 Miss. 66, 19 So. 2d 424, 1944 Miss. LEXIS 276 (Miss. 1944).

Code 1942, Chapter on Insurance, §§ 5616-5834, regulating insurance companies and prescribing the duties of the commissioner of insurance in regard to the examination thereof, does not abrogate or repeal the common-law right of a stockholder in a domestic insurance corporation to inspect the books and records of the corporation. Sanders v. Neely, 197 Miss. 66, 19 So. 2d 424, 1944 Miss. LEXIS 276 (Miss. 1944).

State can regulate insurance under police power, and prescribe kind of contracts to be made. State v. Alley, 96 Miss. 720, 51 So. 467, 1910 Miss. LEXIS 183 (Miss. 1910); General Acci., Fire & Life Assurance Co. v. Walker, 99 Miss. 404, 55 So. 51, 1910 Miss. LEXIS 32 (Miss. 1910).

Statutes regulating insurance liberally construed so as to cover all kinds of insurance. State v. Alley, 96 Miss. 720, 51 So. 467, 1910 Miss. LEXIS 183 (Miss. 1910).

2. What constitutes business of insurance.

General Acci., Fire & Life Assurance Co. v. Walker, 99 Miss. 404, 55 So. 51, 1910 Miss. LEXIS 32 (Miss. 1910).

Whether concern is subject to the insurance law is determined by the nature of the business it transacts without regard to its name. State v. Alley, 96 Miss. 720, 51 So. 467, 1910 Miss. LEXIS 183 (Miss. 1910).

Fact that association confines itself to insurance on a particular kind of property does not take it out of the statute. State v. Alley, 96 Miss. 720, 51 So. 467, 1910 Miss. LEXIS 183 (Miss. 1910).

This section [Code 1942, § 5631] indicates a purpose to include in its provisions all concerns doing an insurance business on any kind of plan. State v. Alley, 96 Miss. 720, 51 So. 467, 1910 Miss. LEXIS 183 (Miss. 1910).

Mutual fire insurance company having no capital stock and empowered by its charter to insure property of members only cannot be authorized to do business in this state. Farmers' Mut. Fire Ins. Co. v. Cole, 90 Miss. 508, 43 So. 949, 1907 Miss. LEXIS 96 (Miss. 1907).

Statute includes foreign associations contracting to pay sick and burial benefits in case of death. Fikes v. State, 87 Miss. 251, 39 So. 783, 1905 Miss. LEXIS 136 (Miss. 1905).

RESEARCH REFERENCES

ALR.

Financing of insurance premiums as constituting "business of insurance" within § 2 of McCarran-Ferguson Act (15 USCS § 1012), excluding application of Truth in Lending Act (15 USCS §§ 1601 et seq.) to such financing. 51 A.L.R. Fed. 743.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 67 et seq.

Practice References.

Business Law Monographs, Volume IN1 —Business Uses of Life Insurance (Matthew Bender Elite Products).

Business Law Monographs, Volume IN2 —Casualty and Liability Insurance (Matthew Bender elite Products).

Insuring Real Property (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-5-3. All companies to submit to all laws of state.

Every insurance company, foreign or domestic, that qualifies to do business in the State of Mississippi shall be required to execute an agreement to be bound by the statute laws of the State of Mississippi pertaining to the periods of limitation prescribed by the statute law of this state.

The insurance commissioner is hereby required, as a condition precedent to authorizing any insurance company to qualify and operate under the laws of this state or to do business in this state, to require said companies to execute an agreement binding said company to conform to and to be bound and regulated by the statute laws of this jurisdiction as defined in the first paragraph.

For purposes of the administration of this section, insurance companies shall consist of all types of insurance companies, both domestic and foreign, that operate in this jurisdiction, including stock companies, mutuals, and fraternal societies and organizations when such fraternal society or organization engages in the insuring of its members or other persons.

HISTORY: Codes, 1942, § 5631.5; Laws, 1956, ch. 343, §§ 1-4.

RESEARCH REFERENCES

ALR.

Insurer's failure to pay amount of admitted liability as precluding reliance on statute of limitations. 41 A.L.R.3d 1111.

Liability of insurer, or insurance agent or adjuster, for infliction of emotional distress. 6 A.L.R.5th 297.

What constitutes "suit" triggering insurer's duty to defend environmental claims–state cases. 48 A.L.R.5th 355.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 63 et seq.

§ 83-5-5. Terms defined.

When consistent with the context and not obviously used in a different sense, the term "company" or "insurance company", as used in this chapter, includes all corporations, associations, partnerships, or individuals engaged as principals in the business of insurance or guaranteeing the obligations of others.

The word "domestic" designates those companies or other insurers incorporated or formed in this state; and the word "foreign", when used without limitation, includes all those formed by authority of any other state or government, and whose home office is not located in this state.

A contract of insurance is an agreement by which one party for a consideration promises to pay money or its equivalent, or to do some act of value to the assured, upon the destruction, loss, or injury of something in which the assured or other party has an interest, as an indemnity therefor.

HISTORY: Codes, 1906, §§ 2562, 2563; Hemingway's 1917, §§ 5027, 5028; 1930, §§ 5130, 5131; 1942, §§ 5632, 5633.

Cross References — Hospital trust to insure against public liability claims not constituting contract of insurance, see § 41-13-107.

Definition of life insurance companies, see § 83-7-1.

JUDICIAL DECISIONS

1. In general.

The Mississippi Municipal Liability Plan does not fit within the definition of insurance under § 83-5-5, which is general liability insurance sufficient to waive sovereign immunity pursuant to § 21-15-6, but instead is self-insurance insufficient to waive sovereign immunity. Morgan v. City of Ruleville, 627 So. 2d 275, 1993 Miss. LEXIS 372 (Miss. 1993).

Corporate administrator of homeowner's warranty program was neither warrantor nor insurer under homeowner's warranty program where it had not agreed to guarantee obligations of any other party involved in program, and, irrespective of any representations which may have been made to plaintiffs by their builders, plaintiffs did not assert that any representative of corporate administrators had made any statements or representations of any sort to plaintiffs. Rather, corporate administrator was administrator of program under which builder issued written guaranty and defendant insurance company underwrote major construction defect policies for certain years; it therefore follows that while corporate administrator may be subjected to liability for its activities relative to its administration of program, it could have no liability to plaintiffs for their claims concerning failure to pay policy benefits. Burley v. Homeowners Warranty Corp., 773 F. Supp. 844, 1990 U.S. Dist. LEXIS 19233 (S.D. Miss. 1990).

Service of process upon foreign insurance company, see National Sur. National Surety Co. v. Board of Sup'rs, 120 Miss. 706, 83 So. 8, 1919 Miss. LEXIS 125 (Miss. 1919).

Statutes liberally construed to cover all kinds of insurance. State v. Alley, 96 Miss. 720, 51 So. 467, 1910 Miss. LEXIS 183 (Miss. 1910).

RESEARCH REFERENCES

ALR.

What is an "insurance company" under § 831(a)(1) of Internal Revenue Code of 1954 (26 USCS § 831(a)(1)), or its predecessors, providing for tax on insurance companies other than life or mutual. 49 A.L.R. Fed. 452.

Am. Jur.

43 Am. Jur. 2d, Insurance § 8.

CJS.

44 C.J.S., Insurance §§ 76-80.

§ 83-5-7. Situs of contract.

It shall be unlawful for any company to make any contract of insurance upon or concerning any property or interest or lives in this state, or with any resident thereof, or for any person as insurance agent or insurance broker to make, negotiate, solicit, or in any manner aid in the transaction of such insurance unless and except as authorized under the provisions of this chapter. All contracts of insurance on property, lives, or interests in this state shall be deemed to be made therein.

HISTORY: Codes, 1906, § 2563; Hemingway's 1917, § 5028; 1930, § 5131; 1942, § 5633.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. What law governs.

1. In general.

Mississippi statutory scheme pertaining to insurance carriers and agents, embodies in §§ 83-5-7, 83-17-103 [repealed], 83-17-105 [repealed], and 97-23-31, allegedly violated by defendants, met 3 criteria for laws to regulate "business of insurance," being (1) whether practice has effect of transferring or spreading a policy holder's risk, (2) whether practice is an integral part of policy relationship between insurer and insured, and (3) whether practice is limited to entities within insurance industry; therefore there was possibility of a valid state law claim based on Mississippi insurance regulatory statutes and/or fraud in the inducement against one of defendants who was insurance agent; accordingly, defendant was not nominal or fraudulently joined party for purposes of removal jurisdiction. Smith v. Arkansas Blue Cross & Blue Shield, 781 F. Supp. 1159, 1991 U.S. Dist. LEXIS 19434 (N.D. Miss. 1991).

Insurance policies providing for life income for assured were annuity policies and not life insurance policies within the purview of this section [Code 1942, § 5633]. Hamilton v. Penn Mut. Life Ins. Co., 196 Miss. 345, 17 So. 2d 278, 1944 Miss. LEXIS 200 (Miss. 1944).

Insurance policies providing for monthly income to assured for life were not life insurance policies, within the purview of statute providing that a policy of life insurance shall not be issued or delivered in this state until the form has been approved and filed by the insurance commissioner, but were annuity policies, notwithstanding that they also provided for payment to another of the balance, if any, of the single premium remaining at the death of assured. Hamilton v. Penn Mut. Life Ins. Co., 196 Miss. 345, 17 So. 2d 278, 1944 Miss. LEXIS 200 (Miss. 1944).

A statute calling for a foreign corporation residing outside the state to designate a person within the state as its agent for service of process in the state in return for the privilege of doing business within the state, is constitutional, and the designation of such agent is a voluntary act by which the corporation consents to be sued in the state; and such consent, when executed in conformity with a valid state statute, extends to any court sitting in the state which applies the laws of the state, including federal courts, and therefore constitutes consent to be sued in federal court in the state and supplants the immunity conferred by rules governing venue. Neirbo Co. v. Bethlehem Shipbuilding Corp., 308 U.S. 165, 60 S. Ct. 153, 84 L. Ed. 167, 1939 U.S. LEXIS 77 (U.S. 1939).

2. What law governs.

Corporation had not carried its burden of showing that application of New York law, as provided in the policy, would have been unreasonable or unjust because there was no showing that the fact that the insurer, a United Kingdom entity whose most substantial relationship in the United States was with New York, where it maintained its agent for service of process and its United States Trust Fund account, did not constitute a reasonable basis for the choice of New York law to govern its marine insurance policy providing hull coverage to an ocean going vessel expected to travel up to 100 miles offshore; nor was there any showing that New York law conflicted with any fundamental purpose of maritime law because to hold that New York law, because it applied uberrimae fidei, conflicted with any fundamental purpose of maritime law, would be to run counter to the great weight of authority which embraced that doctrine in maritime insurance cases. Moreover although the corporation argued that application of New York law would be contrary to fundamental policy of Mississippi, the appellate court found that to the extent that Miss. Code § 83-5-7 impliedly addressed Mississippi conflict of law rules, it was not controlling because in the instant marine insurance case it was maritime, not state, conflict of law rules that governed; therefore, the appellate court's answer to the certified question was that either the general maritime law doctrine of uberrimae fidei or New York law, rather than Mississippi law, governed the parties' rights under the instant marine insurance policy. Great Lakes Reinsurance (UK) PLC v. Durham Auctions Inc., 585 F.3d 236, 2009 U.S. App. LEXIS 22362 (5th Cir. Miss. 2009).

A life insurance policy issued in Mississippi is governed by Mississippi law. Franklin Life Ins. Co. v. Critz, 109 F.2d 417, 1940 U.S. App. LEXIS 3916 (5th Cir. Miss.), cert. denied, 309 U.S. 684, 60 S. Ct. 724, 84 L. Ed. 1027, 1940 U.S. LEXIS 776 (U.S. 1940).

Where on former appeals, terminating in a decision by the federal supreme court, the point raised by demurrer to insurer's plea involved the question whether a provision in a fidelity bond requiring any claim thereunder to be made within 15 months after the termination of the suretyship, was subject to the law of Tennessee where the contract was made at a time when the insured was then located in Tennessee, or subject to the laws of Mississippi, to which insured had removed and where the defalcation occurred, and resulted in a determination that the laws of Tennessee governed, such determination did not preclude subsequent litigation as to the effect of such provision under Tennessee decisions as being a condition precedent to liability of the insurer or merely a postponement of the right to sue. Hartford Acci. & Indem. Co. v. Delta & Pine Land Co., 189 Miss. 496, 195 So. 667, 1940 Miss. LEXIS 100 (Miss.), cert. denied, 311 U.S. 610, 61 S. Ct. 25, 85 L. Ed. 387 (U.S. 1940).

Group policy performable and delivered in Alabama held subject to Alabama law, although insured employee was resident of Mississippi, had never been in Alabama, and employer operated its busses only in Mississippi. Protective Life Ins. Co. v. Lamarque, 180 Miss. 243, 177 So. 15, 1937 Miss. LEXIS 104 (Miss. 1937).

A state may not, without violating the due process clause of the federal constitution, apply to an employee's fidelity insurance contract, entered into in another state, its own statute annulling any contractual limitation of the time for giving notice of claim, although the default occurred after the removal of the insured and his defaulting employee to the state in which the action is brought. Hartford Accident & Indem. Co. v. Delta & Pine Land Co., 292 U.S. 143, 54 S. Ct. 634, 78 L. Ed. 1178, 1934 U.S. LEXIS 703 (U.S. 1934).

Under this section [Code 1942, § 5633], all contracts of insurance on property situated in this state, regardless of where the contracts were made, are declared to be Mississippi contracts, and are construed according to the laws of this state, regardless of any provisions in the contracts to the contrary. Stuyvesant Ins. Co. v. A. C. Smith Motor Sales Co., 135 Miss. 585, 99 So. 575, 1924 Miss. LEXIS 21 (Miss. 1924).

Life insurance policy, issued on the life of a resident of this state, must, in view of this section [Code 1942, § 5633], be construed according to the laws of this state, although made in another state, notwithstanding a provision in the policy to the contrary. Fidelity Mut. Life Ins. Co. v. Miazza, 93 Miss. 18, 46 So. 817, 1908 Miss. LEXIS 108 (Miss. 1908).

RESEARCH REFERENCES

ALR.

Insurable interest predicated upon invalid or unenforceable contract. 9 A.L.R.2d 181.

Condemnation proceedings as affecting insurable interest of property owner. 29 A.L.R.2d 888.

Validity of assignment of life insurance policy to one who has no insurable interest in insured. 30 A.L.R.2d 1310.

Insurable interest of husband or wife in other's property. 27 A.L.R.2d 1059.

Conflict of laws in determination of coverage under automobile liability insurance policy. 110 A.L.R.5th 465.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 23 et seq.

CJS.

44 C.J.S., Insurance §§ 41 et seq.

§ 83-5-9. Business to be conducted in corporate name.

Every insurance company, foreign or domestic, shall conduct its business in this state in its own proper and corporate name; and the policies and contracts of insurance issued by it shall be headed or entitled only by its proper and corporate name. When any such company publishes its assets, it shall, in the same connection and with equal conspicuousness, publish its liabilities, computed on the basis allowed for its annual statements; and any publication purporting to show its capital shall exhibit only the amount of such capital as has actually been paid in cash. Any company or any agent thereof issuing or circulating advertisements in violation of this section shall be punished by a fine of not less than Fifty Dollars ($50.00) nor more than Two Hundred Dollars ($200.00).

HISTORY: Codes, 1880, § 1088; 1892, § 2329; 1906, § 2570; Hemingway's 1917, § 5035; 1930, § 5132; 1942, § 5634.

Cross References — Advertisement of amount of capital, see § 83-19-61.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 74, 78.

CJS.

44 C.J.S., Insurance § 124.

§ 83-5-11. Legal process.

When legal process is served upon the commissioner as attorney for an insurance company, he shall forthwith notify the company of such service by letter prepaid and directed to its secretary or, in the case of a foreign country, to its resident manager, if any, in the United States, and shall, within two (2) days after such service, forward in the same manner a copy of the process served on him to the secretary or manager or to such person as may have been previously designated by the company by written notice filed in the office of the commissioner. The failure of the commissioner to notify the company shall not affect the validity of such service but shall subject him to liability on his bond for such damages as the company shall suffer thereby. As a condition of a valid and effectual service and of the duty of the commissioner in the premises, the plaintiff in such process shall pay to the commissioner at the time of service thereof the sum of Twenty-five Dollars ($25.00), which the plaintiff shall recover as taxable costs if he prevails in his suit. The commissioner shall keep a record of all such proceedings, that shall show the day and hour of service.

HISTORY: Codes, 1906, § 2569; Hemingway's 1917, § 5034; 1930, § 5133; 1942, § 5635; Laws, 1977, ch. 329, § 1; ch. 398, § 1; Laws, 1985, ch. 433, § 8; Laws, 1993, ch. 330, § 1; Laws, 2003, ch. 370, § 1, eff from and after July 1, 2003.

Cross References — Service of process upon agent of trustees or attorneys in fact, see § 13-3-41.

Fees for commissioner, see § 83-5-73.

Appointment of commissioner as attorney for service of process for foreign insurance companies, see § 83-21-1.

Appointment of commissioner as agent for service of process under reciprocal insurance contracts, see § 83-33-7.

Service of process upon commissioner in suits to enforce liens, see § 85-7-195.

JUDICIAL DECISIONS

1. Generally

Supreme Court of Mississippi finds that Miss. Code Ann. § 83-5-11 does not authorize the Mississippi Commissioner of Insurance to act as an agent for service of process for any and every company operating in the insurance business in Mississippi. Cent. Insurers of Gren., Inc. v. Greenwood, 268 So. 3d 493, 2018 Miss. LEXIS 237 (Miss. 2018).

Supreme Court of Mississippi finds that Miss. Code Ann. § 83-5-11 can be interpreted only as providing a procedure for the Mississippi Commissioner of Insurance to follow when he or she is acting as an agent for service of process pursuant to a more specific provision of Miss. Code Ann. tit. 83. Cent. Insurers of Gren., Inc. v. Greenwood, 268 So. 3d 493, 2018 Miss. LEXIS 237 (Miss. 2018).

Trial court erred as a matter of law in holding that the Mississippi Commissioner of Insurance was authorized to act as an insurance producer's agent for service of process purposes where Miss. Code Ann. § 83-5-11 did not authorize the Commissioner to act as an agent for service of process for any and every company operating in the insurance business in Mississippi. Cent. Insurers of Gren., Inc. v. Greenwood, 268 So. 3d 493, 2018 Miss. LEXIS 237 (Miss. 2018).

§ 83-5-13. Laws applicable.

The general provisions of law relative to the powers, duties, and liabilities of corporations shall apply to all incorporated domestic insurance companies, so far as such provisions are pertinent and not in conflict with other provisions of law relative to such companies, or with their charters. All insurance companies in this state shall be governed by this chapter, anything in their special charters to the contrary notwithstanding.

HISTORY: Codes, 1892, § 2330; 1906, § 2571; Hemingway's 1917, § 5036; 1930, § 5134; 1942, § 5636.

Cross References — Laws applicable to foreign insurance companies, see § 83-21-7.

Exclusion of fraternal societies from insurance laws, see § 83-29-7.

RESEARCH REFERENCES

ALR.

Conflict of laws in determination of coverage under automobile liability insurance policy. 110 A.L.R.5th 465.

Am. Jur.

43 Am. Jur. 2d, Insurance § 63.

§ 83-5-15. License fees for each class of business.

No insurance company admitted to do business in the state shall be authorized to transact more than one (1) class or kind of insurance, unless it shall pay the license fees for each class and have the requisite capital for each business engaged in. A life insurance company may do an accident business and a fire insurance company may transact insurance as prescribed in Section 83-19-1, Class 1 subsections (a), (b), and (g), with the payment of the largest license fees provided for any one (1) business done. No insurance company or other insurer shall be required to pay license fees amounting in the aggregate to more than Three Hundred and Fifty Dollars per annum.

HISTORY: Codes, 1906, § 2611; Hemingway's 1917, § 5074; 1930, § 5135; 1942, § 5637.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation inserted ", Class 1" in the second sentence. The Joint Committee ratified the correction at its August 10, 2022, meeting.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 63.

CJS.

44 C.J.S., Insurance §§ 118-120, 131, 132.

§ 83-5-17. Revocation of license; administrative fine; funding of agency expenses; deposit of monies into State General Fund.

The Commissioner of Insurance may, after notice and a hearing, revoke the authority of a domestic or foreign insurance company or impose an administrative fine, or both, if it violates or neglects to comply with any provision of law obligatory on it, and whenever in the opinion of the commissioner its condition is unsound, or its assets above its liabilities, exclusive of capital and inclusive of unearned premiums, are less than the amount of its original capital or required unimpaired funds. Such administrative fine shall not exceed Five Thousand Dollars ($5,000.00) per violation and shall be deposited into the special fund in the State Treasury designated as the "Insurance Department Fund."

From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1906, § 2612; Hemingway's 1917, § 5075; 1930, § 5136; 1942, § 5638; Laws, 1997, ch. 410, § 3; Laws, 2016, ch. 459, § 21, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Power of commissioner to suspend or revoke certificates of authority, see § 83-1-29.

Revocation of license for failure to comply with insurance laws, see § 83-5-83.

Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

Application of this section to suspension, revocation or refusal of license for failure to submit to examination by commissioner, see § 83-5-207.

Violation of Sections 83-7-301 through 83-7-313 not subject to penalty provisions under this section, see § 83-7-307.

Revocation of certificate of authority for impairment of capital, see § 83-19-57.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance § 139.

§ 83-5-19. Sale of stock regulated.

(1) No insurance company, corporation, or association of individuals shall sell or offer to sell stock in any insurance company or any insurance agency company, or permit the same to be sold or offered for sale by any firm, company, corporation, or individual to any person or persons in Mississippi until the same secures a permit or license from the insurance commissioner. Before such permit shall be granted for the sale of such stock in this state, directly or indirectly, by itself or by any firm, person, or corporation, such insurance company, corporation, or association of individuals shall file with the insurance commissioner a duly certified copy of its articles of incorporation and designate the insurance commissioner attorney for the service of legal process, as now provided by law for other insurance companies or corporations, and shall file with the insurance commissioner such other information, with reference to its proposed plans of transacting business in Mississippi, as the insurance commissioner may require. If, after an examination of such articles of incorporation, and upon being otherwise satisfied that the business proposed to be transacted in the state is proper and right under the laws of Mississippi, then the insurance commissioner shall issue the same a permit to sell its stock in the State of Mississippi.

(2) Permit–Two Hundred Dollars $200 paid for examination:

Every such insurance company, corporation, or association of individuals shall pay to the insurance commissioner the sum of Two Hundred Dollars ($200.00) for his services in making the examination and issuing the permit provided by the preceding subsection; and every agent, person, or corporation offering the stock for sale shall pay to the said commissioner the sum of Ten Dollars ($10.00). Said sums shall be paid into the state treasury as other taxes collected by him. The license shall only permit such sales to be made upon plan submitted to the insurance commissioner, and at the prices and commissions designated in such license.

(3) Failure to obtain permit:

For failure or refusal to obtain authority provided for herein, such insurance company, corporation, or association of individuals so failing or refusing to obtain such permit shall be forever barred from admission to this state to transact insurance. No person, firm, or corporation shall in any manner represent, as agent or otherwise, such insurance company, corporation, or association of individuals for the sale of stock, or for any other purpose, before securing the permit herein provided.

(4) Sale of insurance and stock together prohibited:

No company, corporation, or other person within the terms of this section shall sell such stock and insurance together, or one as an inducement to the sale or purchase of the other and, for any violation of this section, shall be subject to the same penalties herein otherwise imposed for the violation of any provision of this chapter.

(5) Commissioner given power of trial justice:

For the prosecutions herein provided, the insurance commissioner shall have the powers of a trial justice, or he, or any other person cognizant of the facts, may make affidavit, returnable before a justice of the peace, whose duty it shall be to proceed with the trial as provided by law for any other violation thereof.

HISTORY: Codes, Hemingway's 1917, §§ 5149, 5150, 5151, 5153, 5154; 1930, § 5137; 1942, § 5639; Laws, 1912, ch. 172.

Editor's Notes — Pursuant to Miss. Constn., Art. 6, § 171, all reference in the Mississippi Code to justice of the peace shall mean justice court judge.

Cross References — Notification of company when process is served on commissioner as its attorney, see § 83-5-11.

Issuance of stock by domestic insurance companies, see § 83-19-9.

Procedure for sale of stock issued by domestic insurance companies, see §§ 83-19-35 et seq.

Appointment by foreign insurance company of commissioner as agent for service of process, see § 83-21-1.

Appointment by fraternal societies of commissioner as attorney for service of process, see § 83-29-31.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 63.

§ 83-5-21. License revoked if judgments not paid.

If a judgment shall be rendered by any court in this state against any insurance company, and such judgment shall not be paid and satisfied within ninety (90) days after the same shall have become final, it shall be the imperative duty of the commissioner, immediately upon being advised that such judgment has not been paid or satisfied within the time named, to revoke any and every authority, license, or certificate granted to such insurance company, or any agent thereof, to transact any business in this state until again duly licensed. In case of such revocation, no renewal license or certificate of authority to transact business in this state shall be granted to such insurance company for three (3) years after such revocation, and not then unless such judgment has been satisfied. Whenever such license shall be revoked, the commissioner shall give notice of such revocation by mail to every agent of such insurance company who shall have obtained any certificate of authority to transact business for such insurance company in this state.

HISTORY: Codes, 1906, § 2668; Hemingway's 1917, § 5134; 1930, § 5138; 1942, § 5640; Laws, 1912, ch. 228.

Cross References — Remedy of judgment creditor of fraternal societies, see § 83-29-63.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

CJS.
44 C.J.S., Insurance §§ 124, 129, 130.

§ 83-5-23. Reserves required.

Every company transacting a fire, marine, inland, accident or casualty, surety or fidelity, or other insurance business, except life, in this state shall be required to set aside as a legal reserve to protect the holders of its policy contracts in this state the pro rata unearned portion of the premium paid for such contract, to be held until termination of such contracts, and a reserve for unpaid losses and loss adjustment expenses for incurred claims both reported and unreported. Life insurance companies shall set aside as a reserve sufficient of the premium paid each year which, if invested at four percent (4%) interest, will pay the amount of insurance contracted for at maturity of the contract.

HISTORY: Codes, 1906, § 2614; Hemingway's 1917, § 5077; 1930, § 5139; 1942, § 5641; Laws, 1991, ch. 419, § 1, eff from and after July 1, 1991.

Cross References — Reserve liabilities of life insurance companies, see §§ 83-7-21 et seq.

Reserves required of mutual companies, see § 83-31-31.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 71.	44 C.J.S., Insurance §§ 159-161, 174.

§ 83-5-25. Certain insurance prohibited.

No life insurance company, mutual aid association, fraternal benefit society, order, or association, or stipulated premium companies operating in this state shall hereafter be permitted to issue policies, certificates, or contracts to policyholders or members providing for the establishment of its policyholders or members into divisions and classes for the purpose of providing for the payment of benefits from special funds created for such purpose to the oldest member of the division and class, or to the member of the division and class whose policy has been in force the longest period of time, upon the death of a member in such division and class, except as hereinafter provided.

Any life insurance company, mutual aid association, fraternal benefit society, order, or association, or stipulated premium companies heretofore operating on this plan in this state may continue so to do upon condition that such life insurance company, fraternal benefit society, mutual aid association, or stipulated premium companies shall not hereafter establish its policyholders or members into divisions or classes other than the divisions or classes actually containing subsisting policies or certificates on May 25, 1936.

Any life insurance company, mutual aid association, fraternal benefit society, order, or association, or stipulated premium companies violating any of the provisions of this section shall be subject to the revocation of its license to transact business in this state.

HISTORY: Codes, 1942, § 5642; Laws, 1936, ch. 322.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 68.	44 C.J.S., Insurance § 139.

§ 83-5-27. Discrimination through fictitious grouping prohibited.

No stock, mutual, reciprocal, or other insurer shall make available to any resident or group of residents of this state, through any rating plan or form, fire, inland marine, casualty or surety insurance, or type or combination thereof, whether by master policy, series of policies, certificates of insurance, or otherwise, to any person, firm, corporation, or association of individuals, any preferred rate or premium based upon any fictitious grouping of such person, firm, corporation, or association of individuals, which fictitious grouping is hereby defined and declared to be any grouping by way of membership, license, franchise, agreement, or any other method or means; provided, however, that the foregoing shall not apply to life, accident, health, and hospitalization insurance.

HISTORY: Codes, 1942, § 5649-14; Laws, 1958, ch. 445.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 74.	44 C.J.S., Insurance § 551.

§ 83-5-28. Cancellation, reduction in coverage, or nonrenewal of coverage; notice; inclusion in policies issued or renewed after June 30, 1989; validity and enforcement of replacement policies; transferring insurers requirements.

(1) A cancellation, reduction in coverage or nonrenewal of liability insurance coverage, fire insurance coverage or single premium multiperil insurance coverage is not effective as to any coverage issued or renewed after June 30, 1989, unless notice is mailed or delivered to the insured and to any named creditor loss payee by the insurer not less than thirty (30) days prior to the effective date of such cancellation, reduction or nonrenewal. This section shall not apply to nonpayment of premium unless there is a named creditor loss payee, in which case at least ten (10) days' notice is required. The cancellation and nonrenewal notice requirements of this section shall not apply when a replacement policy form is issued by the same insurer or when a transfer of an insured to a licensed affiliate of the insurer occurs, so long as the replacement of policy forms or transfer results in the same or substantially similar coverage and the insurer mails or delivers to the insured at least thirty (30) days prior to the renewal effective date notice of any term or condition that is less favorable to the policyholder.

(2) The provisions of subsection (1) shall be incorporated into each liability, fire and multiperil policy issued or renewed after June 30, 1989; and if such provisions are not expressly stated in the policy, such provisions shall be deemed to be incorporated in the policy.

(3) Whenever a replacement policy form is issued by the same insurer or when transfer of an insured to a licensed affiliate occurs, documents signed by the insured are applicable to the replacement policy form, the coverage transferred to a licensed affiliate insurer, or both, and remain valid and enforceable.

(4) A transferring insurer shall notify the Mississippi Insurance Department at least forty-five (45) days in advance of notifying a policyholder that its personal or commercial lines insurance policies will be transferred to another licensed insurer within the same insurance group or same holding company. The notice shall include the name of insurer transferring the personal or commercial lines policies and the name and financial rating of the insurer receiving the transferred personal or commercial lines policies.

(5) A transferring insurer shall provide the policyholder written notice of the policy transfer at least thirty (30) days prior to expiration of the policy term and shall include the financial rating of the insurer receiving the transferred policy. Such notice must be provided to the policyholder with the notice of renewal premium at least thirty (30) days before the effective date of the transfer.

(6) As used in this section:

(a) "Affiliate transfer" is when an insurer transfers, at renewal or policy expiration, its personal or commercial lines insurance policies to an affiliated licensed insurer that is a member of the same insurance group or same holding company as the transferring insurer. The issuance of a replacement policy form providing the same or substantially similar coverage issued by the same insurer, or the transfer of personal or commercial insurance policies to a licensed affiliate insurer that will issue the same or substantially similar policy, are considered a renewal and will not be treated as a cancellation or nonrenewal. The affiliate transfer must be to a licensed affiliate insurer that has been determined by the commissioner to have the same or better financial strength as the transferring insurer. The policy transfer must be selected on a nondiscriminatory basis.

(b) "Substantially similar" means a policy that provides the same basic coverages but may add, alter or eliminate incidental coverages and may provide coverages using different textual language.

HISTORY: Laws, 1989, ch. 410, § 1; Laws, 2006, ch. 480, § 1, eff from and after July 1, 2006; Laws, 2018, ch. 312, § 3, eff from and after July 1, 2018.

JUDICIAL DECISIONS

ANALYSIS

1. Strict compliance.
2. Effect on general law of agency.
3. Statutory construction.
4. Notification requirements.

1. Strict compliance.

Mississippi Supreme Court would have required plaintiff insurer to give notice of a reduction in coverage embodied in the second policy directly to defendant insured in strict compliance with Miss. Code Ann. § 83-5-28 (1972) in order to effect a cancellation or a reduction in coverage. The insurer contended that it complied with this legal requirement when its agent gave notice of the policy change to the agent who purchased the policy at the behest of the insured; however, this contention ran afoul of the specific statutory requirement that notice be given by the insurer to the insured. Great Am. Ins. Co. v. Lowry Dev., LLC, 524 F. Supp. 2d 778, 2007 U.S. Dist. LEXIS 80413 (S.D. Miss. 2007), rev'd, 576 F.3d 251, 2009 U.S. App. LEXIS 15862 (5th Cir. Miss. 2009).

2. Effect on general law of agency.

Insured developer was bound by a renewal of a builder's risk policy that included a wind exclusion, as to which its agent failed to give it notice, because Miss. Code Ann. § 83-5-28(1) did not prevent notices of policy changes from being sent to an agent or alter state law, which deemed notification to an agent as adequate notice to the principal. Great Am. Ins. Co. v. Lowry Dev. LLC, 576 F.3d 251, 2009 U.S. App. LEXIS 15862 (5th Cir. Miss. 2009).

3. Statutory construction.

Under the statutory construction principles in Miss. Code Ann. § 1-3-65, the term "insured" in Miss. Code Ann. § 83-5-28 refers to a person involved in a contract with an insurer; the term does not have a technical meaning that would block the common interpretation that authorizing a person to act in a certain way also authorizes a person's agents to do so. Great Am. Ins. Co. v. Lowry Dev. LLC, 576 F.3d 251, 2009 U.S. App. LEXIS 15862 (5th Cir. Miss. 2009).

4. Notification requirements.

Circuit court properly granted partial summary judgment in favor of a lender in its action to pay for the loss of the insureds' chicken farm because the insurer and brokerage failed to comply with the statutory notification requirements inasmuch as the binder was sufficient to trigger the statutory notification requirements where the record showed that the insurance binder issued by the brokerage and the insurer listed the lender as a mortgagee/loss payee, included the lender's mailing address, and the insurer did not contract to require that a premium be paid before the binder went into effect. James Allen Ins. Brokers v. First Fin. Bank, 267 So. 3d 759, 2019 Miss. LEXIS 165 (Miss. 2019).

RESEARCH REFERENCES

Practice References.

Business Law Monographs, Volume IN2—Casualty and Liability Insurance (Matthew Bender).

§ 83-5-29. Insurance business practices regulated.

The purpose of Sections 83-5-29 through 83-5-51 is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945 (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or deceptive practices, and by prohibiting the trade practices so defined or determined.

HISTORY: Codes, 1942, § 5649-01; Laws, 1956, ch. 329, § 1.

Cross References — Application of this section to sponsors of legal expense insurance plans, see § 83-49-21.

Applicability of this section to risk retention groups, see § 83-55-7.

RESEARCH REFERENCES

ALR.

Provisions of insurance company's contract with independent insurance agent restricting competitive placements by agent as illegal restraint of trade under state law. 42 A.L.R.4th 1072.

Am. Jur.

43 Am. Jur. 2d, Insurance § 63.

§ 83-5-30. Insurance business practices regulated; notice of withdrawal, cancelation, or failure to renew insurance; penalties.

Any insurer selling property and casualty insurance shall not withdraw, cancel or fail to renew any line of insurance or class of business without giving notice in writing sixty (60) days in advance to the Commissioner of Insurance. Any failure to give notice may result in a fine of up to Two Thousand Five Hundred Dollars ($2,500.00) in the discretion of the Commissioner of Insurance.

HISTORY: Laws, 1988, ch. 468, eff from and after July 1, 1988.

§ 83-5-31. Insurance business practices regulated; definitions.

When used in Sections 83-5-29 through 83-5-51:

(a) "Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, mutual, interinsurer, Lloyds insurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including agents, solicitors, brokers, and adjusters.

(b) "Commissioner" shall mean the commissioner of insurance of this state.

HISTORY: Codes, 1942, § 5649-02; Laws, 1956, ch. 329, § 2.

Cross References — Application of this section to sponsors of legal expense insurance plans, see § 83-49-21.

Applicability of this section to risk retention groups, see § 83-55-7.

§ 83-5-33. Insurance business practices regulated; unfair methods of competition and deceptive practices prohibited.

No person shall engage in this state in any trade practice which is defined in Sections 83-5-29 through 83-5-51 as, or determined pursuant to said sections to be, an unfair method of competition or an unfair or deceptive act or practice in the business of insurance.

HISTORY: Codes, 1942, 5649-03; Laws, 1956, ch. 329, § 3.

Cross References — Application of this section to sponsors of legal expense insurance plans, see § 83-49-21.

Applicability of this section to risk retention groups, see § 83-55-7.

JUDICIAL DECISIONS

1. In general.

Plaintiffs, applicants for auto and homeowners insurance, could not bring a private cause of action under Miss. Code Ann. § 83-5-33. Wells v. Shelter Gen. Ins. Co., 217 F. Supp. 2d 744, 2002 U.S. Dist. LEXIS 14931 (S.D. Miss. 2002).

There is no provision for private civil action in § 83-5-33. Watson v. First Commonwealth Life Ins. Co., 686 F. Supp. 153, 1988 U.S. Dist. LEXIS 5421 (S.D. Miss. 1988).

Evidence amply supported a finding of liability for tortious interference with contractual rights under §§ 83-5-33, 83-5-35(a), and 83-5-37, based upon the unfair insurance competition practice of "twisting," which is misrepresentation or misstatement of fact, or incomplete comparison of policies, to induce an insured to give up a policy in one company for the purpose of taking insurance in another, where it was adequately shown that there were wrong ages of insureds on the defendant insurer's policies, which corresponded to the insureds' ages on the plaintiff insurer's policies, written two to three years earlier, that no notice was sent by defendant insurer to plaintiff insurer that defendant was replacing plaintiff's policies with its own, as required by an insurance regulation, and that defendant insurer's agents did not tell plaintiff insurer's policyholders about vested rights in their existing policies. Protective Service Life Ins. Co. v. Carter, 445 So. 2d 215, 1983 Miss. LEXIS 3016 (Miss. 1983).

RESEARCH REFERENCES

ALR.

Implied warranty coverage for service transactions under state consumer protection and deceptive trade statutes. 72 A.L.R.4th 282.

Constitutional right to jury trial in cause of action under state unfair or deceptive trade practices law. 54 A.L.R.5th 631.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 74, 78.

31 Am. Jur. Proof of Facts 2d 323, Insurer's Breach of Covenant of Good Faith and Fair Dealing-First-Party Claims.

CJS.

44 C.J.S., Insurance §§ 139, 551.

§ 83-5-35. Insurance business practices regulated; unfair methods of competition and unfair or deceptive acts or practices defined.

The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

(a) **Misrepresentations and false advertising of policy contracts.** Making, issuing, circulating, or causing to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of any policy issued or to be issued, or the benefits or advantages promised thereby, or the dividends or share of the surplus to be received thereon; or making any false or misleading statement as to the dividends or share of surplus previously paid on similar policies; or making any misleading representation or any misrepresentation as to the financial condition of any insurer, or as to the legal reserve system upon which any life insurer operates; or using any name or title of any policy or class of policies misrepresenting the true nature thereof; or making any misrepresentation to any policyholder insured in any company for the purpose of inducing or tending to induce such policyholder to lapse, forfeit, or surrender his insurance.

(b) **False information and advertising generally.** Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading.

(c) **Defamation.** Making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false and maliciously critical of or derogatory to the financial condition of an insurer, and which is calculated to injure any person engaged in the business of insurance.

(d) **Boycott, coercion and intimidation.** Entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion, or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the business of insurance.

(e) **False financial statements.** Filing with any supervisory or other public official, or making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or causing directly or indirectly to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false statement of financial condition of an insurer, with intent to deceive.

Making any false entry in any book, report, or statement of any insurer with intent to deceive any agent or examiner lawfully appointed to examine into its condition or into any of its affairs, or any public official to whom such insurer is required by law to report or file, or who has authority by law to examine into its condition or into any of its affairs, or, with like intent, willfully omitting to make a true entry of any material fact pertaining to the business of such insurer in any book, report, or statement of such insurer.

(f) **Stock operations and insurance company advisory board contracts.** Issuing or delivering, or permitting agents, officers, or employees to issue or deliver, agency company stock or other capital stock, or benefit certificates or shares in any corporation, or securities, or any special or any insurance company advisory board contracts or other contracts of any kind promising returns and profit as an inducement to insurance.

(g) **Unfair discrimination.** (i) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract.

(ii) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever.

(iii) Any violation of Section 83-71-7, 83-71-57 or 83-71-107.

(h) **Designation of agent, solicitor, or insurer.** Requiring as a condition precedent to the purchase or the lending of money upon the security of real or personal property that any insurance covering such property or liability arising from the ownership, maintenance, or use thereof, to be procured by or on behalf of the vendee or by borrower in connection with such purchase or loan, be so procured through any particular person, agent, solicitor, or in any particular insurer.

This section shall not prevent the reasonable exercise by any such vendor or lender of his right to approve or disapprove the insurer selected to underwrite the insurance, and to determine the adequacy of the insurance offered.

(i) Any violation of Sections 83-3-33 and 83-3-121, Mississippi Code of 1972.

HISTORY: Codes, 1942, § 5649-04; Laws, 1956, ch. 329, § 4; Laws, 2010, ch. 455, § 25, eff from and after July 1, 2010.

Editor's Notes — Section 83-3-33, referred to in item (i) of this section, was repealed by Laws, 1987, ch. 422, § 30, effective January 1, 1988.

Cross References — Procedure as to unfair methods of competition and unfair practices which are not defined in this section, see § 83-5-45.

Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

Prohibition of use of name of Mississippi Life and Health Insurance Guaranty Association in insurance advertisements see § 83-23-235.

Violating this section constituting grounds for revocation, suspension or denial or license for legal expense insurance, see § 83-49-11.

Application of this section to sponsors of legal expense insurance plans, see § 83-49-21.

Applicability of this section to risk retention groups, see § 83-55-7.

JUDICIAL DECISIONS

1. In general.

Claim by employee covered under employer's health insurance plan that insurer tortiously breached contract with employee by refusing to pay for daughter's eye surgery was preempted by ERISA, and attempt to characterize action as based on state "twisting statute" (§ 83-5-35) would not overcome preemption. Perkins v. Time Ins. Co., 898 F.2d 470, 1990 U.S. App. LEXIS 5776 (5th Cir. Miss. 1990).

Miss Code Annotated § 83-5-33 does not provide for private civil actions, and no right of civil action is implied. Watson v. First Commonwealth Life Ins. Co., 686 F. Supp. 153, 1988 U.S. Dist. LEXIS 5421 (S.D. Miss. 1988).

Evidence amply supported a finding of liability for tortious interference with contractual rights under §§ 83-5-33, 83-5-35(a), and 83-5-37, based upon the unfair insurance competition practice of "twisting," which is misrepresentation or misstatement of fact, or incomplete comparison of policies, to induce an insured to give up a policy in one company for the purpose of taking insurance in another, where it was adequately shown that there were wrong ages of insureds on the defendant insurer's policies, which corresponded to the insureds' ages on the plaintiff insurer's policies, written two to three years earlier, that no notice was sent by defendant insurer to plaintiff insurer that defendant was replacing plaintiff's policies with its own, as required by an insurance regulation, and that defendant insurer's agents did not tell plaintiff insurer's policyholders about vested rights in their existing policies. Protective Service Life Ins. Co. v. Carter, 445 So. 2d 215, 1983 Miss. LEXIS 3016 (Miss. 1983).

RESEARCH REFERENCES

ALR.

Doctrine of unconscionability as applied to insurance contracts. 86 A.L.R.3d 862.

Propriety of automobile insurer's policy of refusing insurance, or requiring advanced rates, because of age, sex, residence, or handicap. 33 A.L.R.4th 523.

Failure to disclose terminal illness as basis for life insurer's avoidance of high-risk, high-premium policy requiring no health warranties or proof of insurability. 42 A.L.R.4th 158.

Provisions of insurance company's contract with independent insurance agent restricting competitive placements by agent as illegal restraint of trade under state law. 42 A.L.R.4th 1072.

Implied warranty coverage for service transactions under state consumer protection and deceptive trade statutes. 72 A.L.R.4th 282.

Coverage of insurance transactions under state consumer protection statutes. 77 A.L.R.4th 991.

Insurer's duty, and effect of its failure, to provide insured or payee with copy of policy or other adequate documentation of its terms. 78 A.L.R.4th 9.

Constitutional right to jury trial in cause of action under state unfair or deceptive trade practices law. 54 A.L.R.5th 631.

Waiver of estoppel of insurer on basis of statements of omissions in promotional, illustrative, or explanatory materials given to insured. 63 A.L.R.5th 427.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim – Particular conduct of insurer. 115 A.L.R.5th 589.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim – Particular grounds for denial of claim: matters relating to policy. 116 A.L.R.5th 247.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith in failure to pay, or delay in paying, insured's claim-Particular grounds for denial of claim: risks, causes, and extent of loss, injury, disability, or death. 123 A.L.R.5th 259.

Financing of insurance premiums as constituting "business of insurance" within § 2 of McCarran-Ferguson Act (15 USCS § 1012), excluding application of Truth in Lending Act (15 USCS §§ 1601 et seq.) to such financing. 51 A.L.R. Fed. 743.

"Redlining," consisting of denial of home loans or insurance coverage in certain neighborhoods, as discrimination in violation of §§ 804 and 805 of Fair Housing Act

(42 USCS §§ 3604, 3605). 73 A.L.R. Fed. 899.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 74, 78.

29 Am. Jur. Trials 481, Defense of a First-Party Extra-Contract Claims Action Against a Life, Health and Accident Insurer.

20 Am. Jur. Proof of Facts 2d 59, Insured's "Reasonable Expectations" as to Coverage of Insurance Policy.

31 Am. Jur. Proof of Facts 2d 323, Insurer's Breach of Covenant of Good Faith and Fair Dealing-First-Party Claims.

49 Am. Jur. Proof of Facts 2d 1, Fire Insurer's Bad Faith in Responding to Claim by Insured.

CJS.

44 C.J.S., Insurance §§ 139, 551.

§ 83-5-37. Insurance business practices regulated; power of commissioner.

The commissioner shall have power to examine and investigate into the affairs of every person engaged in the business of insurance in this state in order to determine whether such person has been or is engaged in any unfair method of competition or in any unfair or deceptive act or practice prohibited by Section 83-5-33.

HISTORY: Codes, 1942, § 5649-05; Laws, 1956, ch. 329, § 5.

Cross References — Application of this section to sponsors of legal expense insurance plans, see § 83-49-21.

Applicability of this section to risk retention groups, see § 83-55-7.

JUDICIAL DECISIONS

1. In general.

Evidence amply supported a finding of liability for tortious interference with contractual rights under §§ 83-5-33, 83-5-35(a), and 83-5-37, based upon the unfair insurance competition practice of "twisting," which is misrepresentation or misstatement of fact, or incomplete comparison of policies, to induce an insured to give up a policy in one company for the purpose of taking insurance in another, where it was adequately shown that there were wrong ages of insureds on the defendant insurer's policies, which corresponded to the insureds' ages on the plaintiff insurer's policies, written two to three years earlier, that no notice was sent by defendant insurer to plaintiff insurer that defendant was replacing plaintiff's policies with its own, as required by an insurance regulation, and that defendant insurer's agents did not tell plaintiff insurer's policyholders about vested rights in their existing policies. Protective Service Life Ins. Co. v. Carter, 445 So. 2d 215, 1983 Miss. LEXIS 3016 (Miss. 1983).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 67.

§ 83-5-39. Insurance business practices regulated; hearings on charges of unfair practices.

(1) Whenever the commissioner shall have reason to believe that any such person has been engaged or is engaging in this state in any unfair method of

competition or any unfair or deceptive act or practice defined in Section 83-5-35, and that a proceeding by him in respect thereto would be to the interest of the public, he shall issue and serve upon such person a statement of the charges in that respect and a notice of the hearing thereon to be held at the time and place fixed in the notice, which shall not be less than ten (10) days after the date of the service thereof.

(2) At the time and place fixed for such hearing, such person shall have an opportunity to be heard and to show cause why an order should not be made by the commissioner requiring such person to cease and desist from the acts, methods, or practices so complained of. Upon good cause shown, the commissioner shall permit any person to intervene, appear, and be heard at such hearing by counsel or in person.

(3) Nothing contained in Sections 83-5-29 through 83-5-51 shall require the observance at any such hearing of formal rules of pleadings or evidence.

(4) The commissioner, upon such hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance, and require the production of books, papers, records, correspondence, or other documents which he deems relevant to the inquiry. The commissioner, upon such hearing, may, and upon the request of any party shall, cause to be made a stenographic record of all the evidence and all the proceedings had at such hearing. If no stenographic record is made and if a judicial review is sought, the commissioner shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the circuit court of Hinds County, on application of the commissioner, may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

(5) Statements of charges, notices, orders, and other processes of the commissioner under the cited sections may be served by anyone duly authorized by the commissioner, either in the manner provided by law for service of process in civil actions or by registering and mailing a copy thereof to the person affected by such statement, notice, order, or other process at his or its residence or principal office or place of business. The verified return by the person so serving such statement, notice, order, or other process, setting forth the manner of such service, shall be proof of the same; and the return postcard receipt for such statement, notice, order, or other process, registered and mailed as aforesaid, shall be proof of the service of the same.

HISTORY: Codes, 1942, § 5649-06; Laws, 1956, ch. 329, § 6.

Cross References — Application of this section to sponsors of legal expense insurance plans, see § 83-49-21.

Applicability of this section to risk retention groups, see § 83-55-7.

Application of this section to a hearing held to determine if any person has engaged, or is engaging, in any unfair method of competition or any unfair or deceptive act or practice or is engaging in the business of home warranty without being properly licensed, see § 83-57-63.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 67.	44 C.J.S., Insurance §§ 81-83.

§ 83-5-41. Insurance business practices regulated; cease and desist orders and modifications thereof; administrative fines; funding of agency expenses; deposit of monies into State General Fund.

(1) If, after such hearing, the commissioner shall determine that the method of competition or the act or practice in question is defined in Section 83-5-35, and that the person complained of has engaged in such method of competition, act or practice in violation of Sections 83-5-29 through 83-5-51, he shall reduce his findings to writing and shall issue and cause to be served upon the person charged with the violation an order requiring such person to cease and desist from engaging in such method of competition, act or practice. In addition to, or in lieu of, the cease and desist order, the commissioner may, after such hearing, impose an administrative fine not to exceed Five Thousand Dollars ($5,000.00) per violation, which shall be deposited into the special fund in the State Treasury designated as the "Insurance Department Fund."

(2) Until the expiration of the time allowed under Section 83-5-43(1) for filing a petition for review (by appeal), if no such petition has been duly filed within such time or, if the petition for review has been filed within such time, then until the transcript of the record in the proceeding has been filed in the circuit court, as hereinafter provided, the commissioner may at any time, upon such notice and in such manner as he shall deem proper, modify or set aside in whole or in part any order issued by him under this section.

(3) After the expiration of the time allowed for filing such a petition for review, if no such petition has been duly filed within such time, the commissioner may, at any time after notice and opportunity for hearing, reopen and alter, modify, or set aside, in whole or in part, any order issued by him under this section whenever in his opinion conditions of fact or of law have so changed as to require such action, or if the public interest shall so require.

(4) From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

(5) From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1942, § 5649-07; Laws, 1956, ch. 329, § 7; Laws, 1997, ch. 410, § 4; Laws, 2016, ch. 459, § 22, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Judicial review of cease and desist orders, see § 83-5-43.

When cease and desist order issued under this section becomes final, see § 83-5-43.

Penalty for violation of cease and desist order, see § 83-5-49.

Application of this section to sponsors of legal expense insurance plans, see § 83-49-21.

Applicability of this section to risk retention groups, see § 83-55-7.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 67.

CJS.

44 C.J.S., Insurance §§ 81-83.

§ 83-5-43. Insurance business practices regulated; judicial review of cease and desist orders.

(1) Any person required by an order of the commissioner under Section 83-5-41 to cease and desist from engaging in any unfair method of competition or any unfair or deceptive act or practice defined in Section 83-5-35 may obtain a review of such order by filing in the Circuit Court of Hinds County, within thirty (30) days from the date of the service of such order, a written petition praying that the order of the commissioner be set aside. A copy of such petition shall be forthwith served upon the commissioner, and thereupon the commissioner forthwith shall certify and file in such court a transcript of the entire record in the proceeding, including all the evidence taken and the report and order of the commissioner. Upon such filing of the petition and transcript, such court shall have jurisdiction of the proceeding and of the question determined therein, shall determine whether the filing of such petition shall operate as a stay of such order of the commissioner, and shall have power to make and enter upon the pleadings, evidence, and proceedings set forth in such transcript a judgment modifying, affirming, or reversing the order of the commissioner, in whole or in part. The findings of the commissioner as to the facts, if supported by substantial evidence, shall be conclusive.

(2) To the extent that the order of the commissioner is affirmed, the court shall thereupon issue its own order commanding obedience to the terms of such order of the commissioner. If either party shall apply to the court for leave to adduce additional evidence, and shall show to the satisfaction of the court that such additional evidence is material and that there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order such additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The commissioner may modify his findings of fact or make new findings by reason of the additional evidence so taken; and he shall file such modified or new findings

which, if supported by substantial evidence, shall be conclusive, and his recommendations, if any, for the modification or setting aside of his original order, with the return of such additional evidence.

(3) A cease and desist order issued by the commissioner under Section 83-5-41 shall become final:

(a) Upon the completion of the time allowed for filing a petition for review if no such petition has been duly filed within such time; except that the commissioner may thereafter modify or set aside his order to the extent provided in Section 83-5-41(2) or

(b) Upon the final decision of the court if the court directs that the order of the commissioner be affirmed or the petition for review dismissed.

(4) No order of the commissioner under Sections 83-5-29 through 83-5-51 or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.

HISTORY: Codes, 1942, § 5649-08; Laws, 1956, ch. 329, § 8.

Cross References — Application of this section to sponsors of legal expense insurance plans, see § 83-49-21.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-5-45. Insurance business practices regulated; procedure as to unfair methods of competition and unfair practices which are not defined; funding of agency expenses; deposit of monies into State General Fund.

(1) Whenever the commissioner shall have reason to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of such business which is not defined in Section 83-5-35, that such method of competition is unfair or that such act or practice is unfair or deceptive, and that a proceeding by him in respect thereto would be to the interest of the public, he may issue and serve upon such person a statement of the charges in that respect and a notice of a hearing thereon to be held at a time and place fixed in the notice, which shall not be less than ten (10) days after the date of the service thereof. Each such hearing shall be conducted in the same manner as the hearings provided in Section 83-5-39. The commissioner shall, after such hearing, make a report in writing in which he shall state his findings as to the facts, and he shall serve a copy thereof upon such person.

(2) If such report charges a violation of Sections 83-5-29 through 83-5-51, and if such method of competition, act or practice has not been discontinued, the commissioner may, through the Attorney General of this state, at any time after thirty (30) days after the service of such report, cause a petition to be filed

in the circuit court of this state within the district wherein the person resides, or has his principal place of business, to enjoin and restrain such person from engaging in such method, act or practice. The court shall have jurisdiction of the proceeding and shall have power to make and enter appropriate orders in connection therewith and to issue such writs as are ancillary to its jurisdiction or are necessary in its judgment to prevent injury to the public pendente lite.

(3) A transcript of the proceedings before the commissioner, including all evidence taken and the report and findings, shall be filed with such petition. If either party shall apply to the court for leave to adduce additional evidence and shall show, to the satisfaction of the court, that such additional evidence is material and there were reasonable grounds for the failure to adduce such evidence in the proceeding before the commissioner, the court may order such additional evidence to be taken before the commissioner and to be adduced upon the hearing in such manner and upon such terms and conditions as to the court may seem proper. The commissioner may modify his findings of fact or make new findings by reason of the additional evidence so taken, and he shall file such modified or new findings with the return of such additional evidence.

(4) If the court finds that the method of competition complained of is unfair or that the act or practice complained of is unfair or deceptive, that the proceeding by the commissioner with respect thereto is to the interest of the public, and that the findings of the commissioner are supported by substantial evidence, it shall issue its order enjoining and restraining the continuance of such method of competition, act or practice.

(5) In addition to, or in lieu of, filing, through the Attorney General, a petition for a cease and desist order, the commissioner may, after a hearing in accordance with subsection (1), impose an administrative fine not to exceed Five Thousand Dollars ($5,000.00) per violation, which shall be deposited into the special fund in the State Treasury designated as the "Insurance Department Fund."

(6) From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

(7) From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1942, § 5649-09; Laws, 1956, ch. 329, § 9; Laws, 1997, ch. 410 § 5; Laws, 2016, ch. 459, § 23, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Violation of this section constituting grounds for revocation, suspension or denial of license for legal expense insurance, see § 83-49-11.

Application of this section to sponsors of legal expense insurance plans, see § 83-49-21.

Applicability of this section to risk retention groups, see § 83-55-7.

Application of this section to a hearing held to determine if any person has engaged, or is engaging, in any unfair method of competition or any unfair or deceptive act or practice or is engaging in the business of home warranty without being properly licensed, see § 83-57-63.

RESEARCH REFERENCES

ALR.

Coverage of insurance transactions under state consumer protection statutes. 77 A.L.R.4th 991.

Am. Jur.

43 Am. Jur. 2d, Insurance § 67.

§ 83-5-47. Insurance business practices regulated; judicial review by intervenor.

If the report of the commissioner does not charge a violation of Sections 83-5-29 through 83-5-51, then any intervenor in the proceedings may, within ten (10) days after the service of such report, cause a notice of appeal to be filed in the Circuit Court of Hinds County for a review of such report. Upon such review, the court shall have authority to issue appropriate orders and decrees in connection therewith, including, if the court finds that it is to the interest of the public, orders enjoining and restraining the continuance of any method of competition, act, or practice which it finds, notwithstanding such report of the commissioner, constitutes a violation of the cited sections.

HISTORY: Codes, 1942, § 5649-10; Laws, 1956, ch. 329, § 10.

Cross References — Application of this section to sponsors of legal expense insurance plans, see § 83-49-21.

Applicability of this section to risk retention groups, see § 83-55-7.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 67.

§ 83-5-49. Insurance business practices regulated; penalty for violation of cease and desist order.

Any person who willfully violates a cease and desist order of the commissioner under Section 83-5-41, after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the commissioner for the use of the public schools of the county or counties in which the act or acts complained of occurred, a sum to be determined by the commissioner not to exceed One Thousand Dollars ($1,000.00) for each violation, which if not paid may be recovered in a civil action instituted in the name of the commissioner in a court of competent jurisdiction in the county of the residence of such person who is a resident of the state. In the case of a nonresident, the action shall be brought in a court of competent jurisdiction in Hinds County.

In addition to or in lieu of the penalty set out above, the commissioner may revoke or suspend the license of such person to transact the business of insurance in this state, but from any order of the commissioner revoking or suspending such license, there shall be a right of appeal therefrom to the circuit court of the First Judicial District of Hinds County in the manner provided by law.

HISTORY: Codes, 1942, § 5649-11; Laws, 1956, ch. 329, § 11.

Cross References — Application of this section to sponsors of legal expense insurance plans, see § 83-49-21.

Applicability of this section to risk retention groups, see § 83-55-7.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 69.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance § 139.

§ 83-5-51. Insurance business practices regulated; provisions cumulative.

Sections 83-5-29 through 83-5-51 are hereby declared to be cumulative and supplemental to all other valid statutes relating to insurance companies, agents, solicitors, and brokers, and do not repeal or amend any existing statutes.

HISTORY: Codes, 1942, § 5649-12; Laws, 1956, ch. 329, § 12.

Cross References — Application of this section to sponsors of legal expense insurance plans, see § 83-49-21.

Applicability of this section to risk retention groups, see § 83-55-7.

§ 83-5-53. Blank forms furnished.

It shall be the duty of the commissioner to make available upon request, at the expense of the requesting insurance company, blank forms for statements, which forms may be by him from time to time changed, as may be requisite to secure full information as to the standing, condition, and such other information desired of companies regulated by his department.

HISTORY: Codes, 1906, §§ 2618, 2651; Hemingway's 1917, § 5081; 1930, §§ 5211, 5219; 1942, §§ 5725, 5733; Laws, 2005, ch. 386, § 1, eff from and after July 1, 2005.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance § 96.

§ 83-5-55. Annual and quarterly statements to be filed.

(1) Every insurance company shall file with the Commissioner of Insurance, on or before the first day of March of each year, a statement showing the business standing and financial condition of the company and sworn to by the president or vice president and secretary or treasurer or chief managing agent or officer of such company. The annual statement to be filed shall be in accordance with the NAIC Quarterly and Annual Statement Blank and Instructions thereto and the NAIC Accounting Practices and Procedures Manual.

(2) Every insurance company shall file with the Commissioner of Insurance a quarterly statement showing the business standing and financial condition of the company for that quarter and sworn to by the president or vice president and secretary or treasurer or chief managing agent or officer of such company. Each quarterly statement shall be filed within forty-five (45) days of the last day of the quarter. The quarterly statement to be filed shall be in accordance with the NAIC Quarterly and Annual Statement Blank and Instructions thereto and the NAIC Accounting Practices and Procedures Manual. However, the Commissioner of Insurance may grant an exemption to any domestic company transacting business in Mississippi only. No exemption shall be granted to any domestic company transacting business across state lines.

HISTORY: Codes, 1906, § 2619; Hemingway's 1917, §§ 5082, 5083; 1930, §§ 5212, 5213; 1942, §§ 5726, 5727; Laws, 1916, ch. 202; Laws, 1991, ch. 550, § 1; Laws, 2001, ch. 433, § 1; Laws, 2005, ch. 386, § 2; Laws, 2007, ch. 369, § 1, eff from and after July 1, 2007.

Cross References — Disposition of annual statements, see § 83-1-21.
Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.
Annual reports of burial associations, see § 83-37-19.

JUDICIAL DECISIONS

1. In general.
Duty and responsibility of the commissioner of insurance is prescribed primarily for the protection of the policyholders and the public, and the sections relating thereto were not intended to deal with the relation existing between the insurance corporation and its stockholders, or to require the commissioner to concern himself with the internal affairs and details of operation or management. Sanders v. Neely, 197 Miss. 66, 19 So. 2d 424, 1944 Miss. LEXIS 276 (Miss. 1944).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance § 96.

§ 83-5-57. Reinsurance returns made annually.

Every fire insurance company now or hereafter admitted shall annually, and at such other times as the said commissioner may require, in addition to all the returns now, by law, required of it or its agents or managers, make a return to the insurance commissioner in such form and detail as may be prescribed by him of all reinsurance contracted for or affected by it, directly or indirectly, upon property located in Mississippi, such return to be sworn to by its president and secretary, if a company of any other state of the United States, and if a company of a foreign country by its president and secretary or by officers corresponding thereto, as to reinsurance as aforesaid contracted for or effected through the foreign office, and by the United States manager as to such reinsurance effected by the United States branch. If any company, domestic or foreign, shall directly or indirectly reinsure any risk taken by it on any property located in Mississippi in any company not duly authorized to transact business herein, except as hereinbefore provided, or if it shall refuse or neglect to make the returns required by this section, the said commissioner shall revoke its authority to transact business in this state.

HISTORY: Codes, 1906, § 2608; Hemingway's 1917, § 5071; 1930, § 5210; 1942, § 5724.

Cross References — Regulation of reinsurance by fire insurance companies, see § 83-13-1.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance § 96.

§ 83-5-59. Statements examined and abstracts published.

It shall be the duty of the commissioner to receive and thoroughly examine each annual statement required by this chapter and, if made in compliance with the law of Mississippi, to publish at the expense of the company an abstract of the same in one of the newspapers of the state, to be selected by the company. Such company shall, within thirty (30) days after the filing of such statement, notify the commissioner in writing of the name of the paper selected by it; otherwise, the paper shall be selected by the commissioner.

HISTORY: Codes, 1906, § 2620; Hemingway's 1917, § 5084; 1930, § 5214; 1942, § 5728; Laws, 1960, ch. 369, § 1.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 70.	44 C.J.S., Insurance § 96.

§ 83-5-61. Certain premiums declared and taxed.

All corporations, firms, persons, or individuals obtaining insurance on property situate in this state owned by corporations, firms, or individuals resident therein, against fire, lightning, or tornado from companies, associations, firms, or corporations not authorized to transact business in this state, shall file with the insurance commissioner of the state a sworn statement or declaration, setting forth the name of the company, number of policy, amount of insurance rate, premium, and description, shall be required to pay to the insurance commissioner a tax thereon of three percent (3%) of the premiums paid on said policies, and shall further pay to said commissioner a fee of One Dollar ($1.00) on each policy for filing a record of the said statement or declaration, which record shall be kept for the private information of the insurance department and shall not be a public record.

HISTORY: Codes, 1906, § 2625; Hemingway's 1917, § 5090; 1930, § 5217; 1942, § 5731; Laws, 1912, ch. 226.

Cross References — Privilege tax levied on foreign insurance company, see §§ 27-15-103 et seq.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 70.	44 C.J.S., Insurance §§ 96, 118-120, 131, 132.

§ 83-5-63. Penalty for failure to declare.

Any corporation, firm, person, or individual, resident in this state, who shall obtain or have possession of policies of insurance against loss by fire, lightning, or tornado on property situate in this state issued by companies, associations, firms, corporations, or individuals not authorized to transact the business of insurance in this state without complying with the provisions of Section 83-5-61 shall be guilty of a misdemeanor and, upon conviction thereof, shall be subject to a fine of not less than Two Hundred Fifty Dollars ($250.00) nor more than One Thousand Dollars ($1,000.00). Nothing herein shall prevent the placing of insurance in unauthorized companies as provided elsewhere by this chapter.

HISTORY: Codes, Hemingway's 1917, § 5091; 1930, § 5218; 1942, § 5732; Laws, 1912, ch. 226.

Cross References — Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 69.

CJS.
44 C.J.S., Insurance § 139.

§ 83-5-65. Books exhibited.

It shall be the duty of any person having in his possession or control any books, accounts, or papers of any person licensed under this chapter to exhibit the same to the commissioner on demand. On refusing to do so or knowingly or wilfully making any false statement in regard to the same, such person shall be deemed guilty of a misdemeanor and, upon conviction thereof, shall be fined or imprisoned, or both, at the discretion of the court.

HISTORY: Codes, 1906, § 2622; Hemingway's 1917, § 5086; 1930, § 5215; 1942, § 5729.

Cross References — Applicability of this section to agents and brokers for risk retention groups and purchasing groups, see § 83-55-7.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-5-67. License revoked if statement untrue.

If the commissioner shall become satisfied at any time that any statements made by any person licensed under this chapter shall be untrue, or in case the general agent should fail or refuse to obey the provisions of this chapter, the commissioner shall have power to revoke and cancel such license.

HISTORY: Codes, 1906, § 2621; Hemingway's 1917, § 5085; 1930, § 5220; 1942, § 5734.

Cross References — Application of this section to suspension, revocation or refusal of license for failure to submit to examination by commissioner, see § 83-5-207.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.
14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.
44 C.J.S., Insurance § 124.

§ 83-5-69. Penalty for failure to file statements and making false return; funding of agency expenses; deposit of monies into State General Fund.

Any company that neglects to make and file its quarterly and annual statement within the time provided in this chapter shall pay to the Commissioner of Insurance One Hundred Dollars ($100.00) for each day's neglect, which penalty shall be deposited into the special fund in the State Treasury designated as the "Insurance Department Fund"; and upon notice by the commissioner to that effect, its authority to do new business shall cease while such default continues. For willfully making a false annual, quarterly or other statement it is required by law to make, any insurance company, association or order, and the person making oath to or subscribing the same, shall severally be guilty of a misdemeanor; and, upon conviction, be punished by a fine of not less than Five Hundred Dollars ($500.00) nor more than One Thousand Dollars ($1,000.00). Any person making oath to such false statement shall be guilty of the crime of perjury.

From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1906, § 2646; Hemingway's 1917, § 5112; 1930, § 5221; 1942, § 5735; Laws, 2002, ch. 389, § 1; Laws, 2005, ch. 386, § 3; Laws, 2016, ch. 459, § 24, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Perjury, see §§ 97-9-59 through 97-9-65.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 70.	44 C.J.S., Insurance § 96.

§ 83-5-71. License or certificate effective until suspended, revoked, surrendered or forfeited.

(1) Notwithstanding any other provision of law, this section establishes the exclusive authority with respect to the duration of a privilege license or

certificate of authority for an insurer subject to this chapter and licensed or holding a certificate of authority, or both, to transact business in this state under this Title 83.

(2) An insurer must make an initial application in a form prescribed by the commissioner and, upon being granted approval to transact business in this state, a license or certificate of authority, or both, shall be issued and remain in effect until suspended, revoked, surrendered or forfeited.

(3) Before being issued an initial license or certificate of authority, an insurer must pay the required privilege tax fee required by Section 27-15-83, along with other required fees, and must continue to pay the aforementioned fees on an annual basis on or before March 1 of each year in order to keep the license or certificate of authority in good standing.

(4) Amendments to a license or certificate of authority will require payment by the insurer of the applicable fees.

(5) Insurers who were issued a license or certificate of authority, or both, before the effective date of this law will receive an amended license or certificate of authority, or both.

HISTORY: Codes, 1892, § 2343; 1906, § 2624; Hemingway's 1917, § 5089; 1930, § 5216; 1942, § 5730; Laws, 1995, ch. 315, § 1, eff from and after July 1, 1995; Laws, 2022, ch. 473, § 3, eff from and after July 1, 2022.

Amendment Notes — The 2022 amendment rewrote the section, which read: "The licenses issued under this chapter shall continue for the next ensuing twelve (12) months after June 1 of each year unless sooner revoked or suspended by the commissioner."

Cross References — Annual license for fraternal society, see § 83-29-27.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 21 (petition or application for writ of mandamus to compel renewal of license to conduct insurance business).

14 Am. Jur. Pl & Pr Forms (Rev), Form No. 24 (notice of intention to apply for peremptory writ of mandamus to compel renewal of license to conduct insurance business).

14 Am. Jur. Pl & Pr Forms (Rev), Form No. 25 (order for issuance of alternative writ of mandamus to compel renewal of license to conduct insurance business).

14 Am. Jur. Pl & Pr Forms (Rev), Form No. 26 (alternative writ of mandamus to compel renewal of license to conduct insurance business).

14 Am. Jur. Pl & Pr Forms (Rev), Form No. 27 (judgment or decree granting peremptory writ of mandamus to compel renewal of license to conduct insurance business).

14 Am. Jur. Pl & Pr Forms (Rev), Form No. 28 (peremptory writ of mandamus to compel renewal of license to conduct insurance business).

CJS.

44 C.J.S., Insurance §§ 118-120.

§ 83-5-72. Life, health and accident insurance companies and health maintenance organizations to contribute to Insurance Department Fund; funding of agency expenses; deposit of monies into State General Fund.

All life, health and accident insurance companies and health maintenance organizations doing business in this state shall contribute annually, at such times as the Insurance Commissioner shall determine, in proportion to their gross premiums collected within the State of Mississippi during the preceding year, to a special fund in the State Treasury to be known as the "Insurance Department Fund" to be expended by the Insurance Commissioner in the payment of the expenses of the Department of Insurance as the commissioner may deem necessary. The commissioner is hereby authorized to employ such actuarial and other assistance as shall be necessary to carry out the duties of the department; and the employees shall be under the authority and direction of the Insurance Commissioner. The amount to be contributed annually to the fund shall be fixed each year by the Insurance Commissioner at a percentage of the gross premiums so collected during the preceding year. However, a minimum assessment of One Hundred Dollars ($100.00) shall be charged each licensed life, health and accident insurance company regardless of the gross premium amount collected during the preceding year.

The total contributions collected for the Insurance Department Fund shall not exceed the sum of Seven Hundred Fifty Thousand Dollars ($750,000.00) in each fiscal year.

From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Laws, 1990, ch. 557, § 4; Laws, 1991, ch. 430 § 4; Laws, 1998, ch. 451, § 2; Laws, 2016, ch. 459, § 25, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Contributions of property and casualty insurance companies to Insurance Department Fund, see § 83-2-33.

§ 83-5-73. Fees for commissioner; funding of agency expenses; deposit of monies into State General Fund.

The commissioner shall collect and pay into the special fund in the State Treasury designated as the "Insurance Department Fund" the following fees:

for certificate of authority to each general or district agent or manager, Twenty-five Dollars ($25.00); for filing and processing an agent's certificate of authority, Twenty-five Dollars ($25.00); for filing and examining statement preliminary to admission, One Thousand Dollars ($1,000.00); for filing and processing a Form A application, Two Thousand Dollars ($2,000.00); for filing and auditing annual statement, Five Hundred Dollars ($500.00); for filing any other paper required by law, Fifty Dollars ($50.00); for continuing education courses or programs filed by the providers for approval, Fifty Dollars ($50.00); for each certification company licensed status, Forty Dollars ($40.00); for each seal when required, Twenty Dollars ($20.00); for service of process on the commissioner as attorney, Twenty-five Dollars ($25.00).

From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1906, § 2630; Hemingway's 1917, § 5096; 1930, § 5222; 1942, § 5736; Laws, 1977, ch. 329, § 2; ch. 398, § 2; Laws, 1985, ch. 433, § 9; Laws, 1988, ch. 526, § 1; Laws, 1991, ch. 428 § 1; Laws, 1994, ch. 613, § 1; Laws, 2008, ch. 440, § 1; Laws, 2016, ch. 459, § 26, eff from and after July 1, 2016.

Editor's Notes — Section 13 of ch. 526, Laws, 1988, provides as follows:

"SECTION 13. The commissioner may, after notice and hearing, issue rules and regulations that he deems necessary to effectuate the purposes of this act or to eliminate devices or plans designed to avoid or render ineffective the provisions of this act. The commissioner may require such information as is reasonably necessary for the enforcement of this act. All rules and regulations adopted and promulgated pursuant to this act shall be subject to the provisions of the Mississippi Administrative Procedures Law as provided in Section 25-43-1 et seq. [now 25-43-1.101 et seq.], Mississippi Code of 1972."

Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Procedure following service of process on commissioner, see § 83-5-11.

Authority to issue continuous agent certificates, see § 83-15-3.

Privilege tax for continuous agent certificate, see § 83-37-21.

RESEARCH REFERENCES

ALR.

Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

Am. Jur.

43 Am. Jur. 2d, Insurance § 67.

§ 83-5-75. Fees of fraternal orders.

For all larger fraternal orders, as defined in Section 83-30-1, the commissioner shall collect charges as provided in Section 83-5-73, as well as all other fees and charges due and payable by any company, association, order or individual in his department. If a fraternal order would not be considered a larger fraternal order under Section 83-30-1, the commissioner shall collect the following charges: for filing charter, etc., of fraternal orders doing an insurance business, preliminary to admission, Twenty-five Dollars ($25.00); for filing and auditing annual statement, Ten Dollars ($10.00); all other fees and charges due and payable by any company, association, order or individual in his department.

HISTORY: Codes, 1906, § 2631; Hemingway's 1917, § 5097; 1930, § 5223; 1942, § 5737; Laws, 2008, ch. 440, § 2, eff from and after passage (approved Apr. 7, 2008).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-5-77. Publication fees; funding of agency expenses; deposit of monies into State General Fund.

For publication of annual statement, there shall be a fee of Eighty Dollars ($80.00), Forty Dollars ($40.00) of which shall be paid to the publishers and Forty Dollars ($40.00) paid to the special fund in the State Treasury known as the "Insurance Department Fund". The commissioner shall receive for copy of any record or paper in his office, Fifty Cents (50¢) per page, and Twenty Dollars ($20.00) for certifying same, or any fact or data from the records of the office.

From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1906, § 2632; Hemingway's 1917, § 5098; 1930, § 5224; 1942, § 5738; Laws, 1948, ch. 348, § 1; Laws, 1960, ch. 369, § 2; Laws, 1977, ch. 396; Laws, 1988, ch. 526, § 2; Laws, 1997, ch. 324, § 1; Laws, 2008, ch. 440, § 3; Laws, 2016, ch. 459, § 27, eff from and after July 1, 2016.

Editor's Notes — Section 13 of ch. 526, Laws, 1988, provides as follows:

"SECTION 13. The commissioner may, after notice and hearing, issue rules and regulations that he deems necessary to effectuate the purposes of this act or to eliminate devices or plans designed to avoid or render ineffective the provisions of this act. The commissioner may require such information as is reasonably necessary for the enforcement of this act. All rules and regulations adopted and promulgated pursuant to this act shall be subject to the provisions of the Mississippi Administrative Procedures Law as provided in Section 25-43-1 et seq. [now 25-43-1.101 et seq.], Mississippi Code of 1972."

Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

§ 83-5-79. Investigation of complaint by citizens.

Complaint being filed by any citizen of this state that any company authorized to do business in this state has violated any of the provisions of the insurance laws of Mississippi, the commissioner shall diligently investigate the matter and, if necessary, examine by himself or his accredited representatives at the head office located in the United States of America such officers or agents of such company as he may deem proper; also all books, records, and papers of the same, and also the officers thereof under oath, as to such alleged violation or violations. Before making any examinations which would require the commissioner to go to a foreign state, he shall require the party or parties making complaint to file with him a good and sufficient bond to secure any expense or costs that may be necessary in making such examination. In the event that the insurance company be found not guilty of a violation of said insurance laws by the commissioner, the said bond shall be responsible for all expenses incurred by reason of such investigation; but should such company be found guilty of a violation of such laws, then said company shall be responsible for the expense thereof.

HISTORY: Codes, 1906, § 2655; Hemingway's 1917, § 5121; 1930, § 5201; 1942, § 5715.

Cross References — Penalty for failure to exhibit books of company, see § 83-5-65.

General penalty for violation of insurance laws, see § 83-5-85.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 67.

§ 83-5-81. Suit for payment of expense if refused.

If any company shall fail or refuse to pay all legal and reasonable expenses of examination upon the presentation of a bill therefor by the commissioner, then he shall at once institute proceedings against the said company or other insurer for recovery of the same, and for this purpose may attach any of the property of the said company to be found within the jurisdiction of the court before which such proceedings are heard.

HISTORY: Codes, 1906, § 2656; Hemingway's 1917, § 5122; 1930, § 5202; 1942, § 5716.

Cross References — Authority for enforcement of laws by suit, see § 83-1-17.
General penalty for violation of insurance laws, see § 83-5-85.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

CJS.
44 C.J.S., Insurance § 139.

§ 83-5-83. Refusal to comply; license revoked.

If any company, corporation, or association while holding a license to transact the business of insurance in Mississippi shall fail or refuse to comply with any of the provisions or requirements of the insurance laws of this state, it shall be the duty of the commissioner of insurance to notify such company, corporation, or association by registered letter properly addressed and mailed, or by some other form of actual notice in writing delivered to an executive officer of such company, corporation, or association, of his intention to revoke the license of such company, corporation, or association to transact business in this state at the expiration of thirty (30) days after mailing such registered letter, or a date upon which such actual notice is served. If such provisions or requirements are not fully complied with before the expiration of said thirty (30) days, it shall be the duty of the commissioner of insurance to revoke the license of such company, corporation, or association; and in case of such revocation, such company, corporation, or association shall not be entitled to receive another license for a period of one (1) year, and until it shall have fully complied with all such provisions and requirements of said insurance laws.

HISTORY: Codes, Hemingway's 1917, § 5083; 1930, § 5213; 1942, § 5727; Laws, 1916, ch. 202.

Cross References — Suspension or revocation of authority to do business in state, see § 83-1-29.
Revocation of license for violation of law or unsound financial condition, see § 83-5-17.
Application of this section to suspension, revocation or refusal of license for failure to submit to examination by commissioner, see § 83-5-207.

JUDICIAL DECISIONS

1. In general.
Section 83-5-83 provides the procedure to be followed when an insurance company fails to comply with requirements of the statute to have its license renewed. Mississippi Ins. Guaranty Asso. v. Gandy, 289 So. 2d 677, 1973 Miss. LEXIS 1210 (Miss. 1973).

RESEARCH REFERENCES

ALR.
Validity, construction, and effect of statute establishing compensation for claims not paid because of insurer's insolvency. 30 A.L.R.4th 1110.

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

49 Am. Jur. Proof of Facts 2d 1, Fire Insurer's Bad Faith in Responding to Claim by Insured.

CJS.
44 C.J.S., Insurance § 124.

§ 83-5-85. General penalty.

For violation of any provisions of the insurance laws of Mississippi, the penalty whereof is not specially provided, the offender shall be guilty of a misdemeanor and, on conviction, shall be punished by a fine of not more than Five Thousand Dollars ($5,000.00). For expenses in seeking out, detecting, and punishing violations of such laws, the commissioner may assess an additional penalty to be paid by the offender as restitution in an amount to cover such expenses as may be approved by the court.

The penalties authorized by this section are cumulative and supplemental to any other penalty, fine or other sanction, and shall not be a bar to any other civil cause of action or criminal prosecution.

HISTORY: Codes, 1906, § 2649; Hemingway's 1917, § 5115; 1930, § 5301; 1942, § 5815; Laws, 1987, ch. 422, § 26, eff from and after January 1, 1988.

Cross References — Penalties for violation of competitive rating laws for property and casualty insurance, effective from and after January 1, 1988, see § 83-2-29.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 69.

CJS.
44 C.J.S., Insurance § 139.

§ 83-5-87. Contents of residential property insurance policy.

An insurance company shall not issue a residential property insurance policy that fails to include both the causes of loss of fire and extended coverages unless such policy is approved by the commissioner.

HISTORY: Laws, 1987, ch. 422, § 28, eff from and after January 1, 1988.

§ 83-5-89. Reporting arson incidents; rules and regulations.

(1) The Commissioner of Insurance shall establish a program for the collection of information relating to arson incidents occurring in the state. The program shall be administered through an appropriate bureau within the Department of Insurance.

(2) The fire department, sheriff, chief of police or mayor, an agency of the state or political subdivision shall submit any information required on the Uniform Arson Incident Report, established by the Commissioner of Insurance, to the Commissioner of Insurance when an arson incident occurs in their respective jurisdictions.

(3) The Commissioner of Insurance shall promulgate rules to implement the program and may obtain any assistance available from the United States Department of Justice in the accomplishment of this section.

HISTORY: Laws, 1990, ch. 444, § 1, eff from and after July 1, 1990.

§ 83-5-91. Health insurance for person called to serve on active military duty by executive order of the President of the United States.

The Commissioner of Insurance shall issue, within thirty (30) days of March 20, 1991, a directive to every insurance carrier authorized to write health insurance policies in this state to require the following:

(a) Every insurance carrier that is providing health insurance coverage to a person at the time such person is called to serve on active military duty by Executive Order of the President of the United States, upon such person's becoming deactivated from active duty, shall resume providing the same health insurance coverage, including any preexisting condition which was covered, to that person and his or her dependents as the carrier was providing before the person was called to active military duty as provided in paragraphs (b) and (c) herein;

(b) In the case of group coverage, an employee covered under paragraph (a) of this section shall be entitled to the same coverage as the other employees of his or her group that is in effect at the time of his or her deactivation. If there is no longer a group policy in effect upon his or her deactivation, such employee shall be entitled to receive any nongroup coverage that is offered in the nongroup market by that carrier;

(c) In the case of nongroup coverage, a person covered under paragraph (a) of this section shall be entitled to receive the same coverage he or she had before serving on active military duty or if such coverage is no longer available, any other coverage offered in the nongroup market by that carrier; and

(d) Every insurance carrier shall resume such coverage as required in this section regardless of any condition developed by the person and his or her dependents during the time the person was serving on active military duty.

HISTORY: Laws, 1991, ch. 404, § 1, eff from and after passage (approved March 20, 1991).

§ 83-5-93. Proposing party to provide impact report on legislation to enact mandated health care coverage.

Before the Legislature's consideration of any bill that mandates health insurance coverage for specific health services, for specific diseases or for certain providers of health care services as part of any individual or group health insurance policy, the person or organization that seeks sponsorship of such proposal shall submit to the legislative committees to which the proposal is assigned an impact report that assesses the social and financial effects and the medical efficacy of the proposed mandated coverage. For purposes of Sections 83-5-93 and 83-5-95, mandated health insurance coverage shall include any legislative proposal which either mandates the inclusion of certain benefits, coverages or reimbursements for covered health care services in accident and health insurance policies or provides for the mandatory offering of such benefits, coverages or reimbursements in accident and health insurance policies.

HISTORY: Laws, 1993, ch. 373, § 1, eff from and after passage (approved March 15, 1993).

§ 83-5-95. Contents of impact report.

The report required under Section 83-5-93 or assessing the impact of a proposed mandate of health coverage shall include at the minimum and to the extent that information is available, the following:

(a) The social impact, including:

(i) The extent to which the treatment or service is generally utilized by a significant portion of the population;

(ii) The extent to which such insurance coverage is already generally available;

(iii) If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment;

(iv) If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment;

(v) The level of public demand for the treatment or service;

(vi) The level of public demand for individual or group insurance coverage of the treatment or service;

(vii) The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts; and

(viii) The impact of indirect costs which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage.

(b) The financial impact, including:

(i) The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service;

(ii) The extent to which the proposed coverage might increase the use of the treatment or service;

(iii) The extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service;

(iv) The extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders; and

(v) The impact of this coverage on the total cost of health care.

(c) The medical efficacy, including:

(i) The contribution of the insurance coverage to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and

(ii) If the legislation seeks to mandate coverage of an additional class of practitioners:

1. The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and

2. The methods of the appropriate professional organization that assure clinical proficiency.

(d) The effects of balancing the social, economic and medical efficacy considerations, including:

(i) The extent to which the need for coverage outweighs the cost of mandating the benefit for all insureds; and

(ii) The extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for insureds.

HISTORY: Laws, 1993, ch. 373, § 2, eff from and after passage (approved March 15, 1993).

ARTICLE 2.

AUDIT OF FINANCIAL STATEMENTS OF INSURERS.

Sec.

83-5-101. Audited financial report.
83-5-102. Definitions.
83-5-103. Content of annual audited financial report.
83-5-104. Exemptions.
83-5-105. Extensions.
83-5-106. Designation of independent certified public accountants.
83-5-107. Qualifications of independent certified public accountant.
83-5-108. Consolidated or combined audits.
83-5-109. Scope of examination and report of independent certified public accountant.
83-5-110. Notification of adverse financial condition.
83-5-111. Report on significant deficiencies in internal controls.
83-5-112. Accountant's letter of qualifications.
83-5-113. Definition, availability and maintenance of certified public accountant work papers.
83-5-114. Severability.
83-5-115. Authority of Department of Insurance to determine method of calculating values of stocks, bonds and other sureties held by insurer.
83-5-117. Methods of valuation which may be used to calculate values of stocks, bonds and other sureties held by insurer.

Sec.
83-5-119. Requirements for audit committees.
83-5-120. Internal audit function requirements.
83-5-121. Conduct of insurer in connection with the preparation of required reports and documents.
83-5-123. Management's report of internal control over financial reporting.
83-5-125. Canadian and British companies.

§ 83-5-101. Audited financial report.

All insurers shall have an annual audit by an independent certified public accountant and shall file an audited financial report as a supplement to the annual statement on or before June 1 for the year ended December 31 immediately preceding. The Commissioner of Insurance may require an insurer to file an audited financial report earlier than June 1 with ninety (90) days' advance notice to the insurer.

HISTORY: Laws, 1991, ch. 550, § 2, eff from and after July 1, 1991.

Cross References — Content of annual audited financial report, see § 83-5-103. Designation of independent certified public accountants, see § 83-5-106.

RESEARCH REFERENCES

Practice References.

Business Law Monographs (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

Liability of Corporate Officers and Directors, William E. Knepper, Dan A. Bailey, Stacy R. Lane, Katharine B. Bowman, Michael R. Goodstein, Darius N. Kandawalla (Matthew Bender).

§ 83-5-102. Definitions.

As used in Sections 83-5-102 through 83-5-125, the following terms have the respective meanings herein set forth unless the context shall require otherwise:

(a) "Audited financial report" means and includes those items specified in Section 83-5-103.

(b) "Accountant" or "independent certified public accountant" means an independent certified public accountant or accounting firm in good standing with the American Institute of Certified Public Accountants and in all states in which they are licensed to practice; for Canadian and British companies, it means a Canadian chartered or British chartered accountant.

(c) "Commissioner" means the Commissioner of Insurance.

(d) "Department" means the Department of Insurance.

(e) "Indemnification" means an agreement of indemnity or a release from liability where the intent or effect is to shift or limit in any manner the potential liability of the person or firm for failure to adhere to applicable auditing or professional standards, whether or not resulting in part from knowing or other misrepresentations made by the insurer or its representatives.

(f) "Insurer" means an insurer as defined in Section 83-5-1 or an authorized insurer as defined in Section 83-21-17.

(g) "Affiliate" of, or person "affiliated" with, a specific person, is a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(h) "Audit committee" means a committee (or equivalent body) established by the board of directors of an entity for the purpose of overseeing the accounting and financial reporting processes of an insurer or group of insurers, the internal audit function of an insurer or group of insurers (if applicable), and external audits of financial statements of the insurer or group of insurers. The audit committee of any entity that controls a group of insurers may be deemed to be the audit committee for one or more of these controlled insurers solely for the purposes of this section at the election of the controlling person. Refer to Section 83-5-119(e) for exercising this election. If an audit committee is not designated by the insurer, the insurer's entire board of directors shall constitute the audit committee.

(i) "Independent board member" has the same meaning as described in Section 83-5-119(c).

(j) "Group of insurers" means those licensed insurers included in the reporting requirements of Sections 83-6-1 through 83-6-43, or a set of insurers as identified by management, for the purpose of assessing the effectiveness of internal control over financial reporting.

(k) "Internal control over financial reporting" means a process effected by an entity's board of directors, management and other personnel designed to provide reasonable assurance regarding the reliability of the financial statements and includes those policies and procedures that:

(i) Pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of assets;

(ii) Provide reasonable assurance that transactions are recorded as necessary to permit preparation of the financial statements and that receipts and expenditures are being made only in accordance with authorizations of management and directors; and

(iii) Provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use or disposition of assets that could have a material effect on the financial statements.

(*l*) "RBC" means risk-based capital pursuant to Sections 83-5-401 through 83-5-427.

(m) "SEC" means the United States Securities and Exchange Commission.

(n) "Section 404" means Section 404 of the Sarbanes-Oxley Act of 2002 and the SEC's rules and regulations promulgated thereunder.

(o) "Section 404 Report" means management's report on "internal control over financial reporting" as defined by the SEC and the related attestation report of the independent certified public accountant.

(p) "SOX Compliant Entity" means an entity that either is required to be compliant with, or voluntarily is compliant with, all of the following provisions of the Sarbanes-Oxley Act of 2002: (i) the preapproval requirements of Section 201 (Section 10A(i) of the Securities Exchange Act of 1934); (ii) the audit committee independence requirements of Section 301 (Section 10A(m)(3) of the Securities Exchange Act of 1934); and (iii) the internal control over financial reporting requirements of Section 404 (Item 308 of SEC Regulation S-K).

(q) "Internal audit function" means a person or persons who provide independent, objective and reasonable assurance designed to add value and improve an organization's operations and accomplish its objectives by bringing a systematic disciplined approach to evaluate and improve the effectiveness of risk management control and governance processes.

HISTORY: Laws, 1991, ch. 550, § 3; Laws, 2007, ch. 369, § 2; Laws, 2009, ch. 334, § 1, eff from and after Jan. 1, 2010; Laws, 2019, ch. 326, § 1, eff from and after January 1, 2020.

Cross References — Canadian and British companies, see § 83-5-125.

Federal Aspects — Sections 201 and 301 of the Sarbanes-Oxley Act of 2002, see 15 USCS § 78j-1. Section 404 of the Sarbanes-Oxley Act of 2002, see 15 USCS § 7262.

§ 83-5-103. Content of annual audited financial report.

The annual audited financial report shall report the financial position of the insurer as of the end of the most recent calendar year and the results of its operations, cash flows and changes in capital and surplus for the year then ended in conformity with statutory accounting practices prescribed, or otherwise permitted, by the Department of Insurance of the state of domicile.

The annual audited financial report shall include the following:

(a) Report of independent certified public accountant.

(b) Balance sheet reporting admitted assets, liabilities, capital and surplus.

(c) Statement of operations.

(d) Statement of cash flows.

(e) Statement of changes in capital and surplus.

(f) Notes to financial statements. These notes shall be those required by the appropriate NAIC Annual Statement Instructions and the NAIC Accounting Practices and Procedures Manual. The notes shall include a reconciliation of differences, if any, between the audited statutory financial statements and the annual statement filed pursuant to Section 83-5-55 with a written description of the nature of these differences.

(g) The financial statements included in the audited financial report shall be prepared in a form and using language and groupings substantially the same as the relevant sections of the annual statement of the insurer filed with the commissioner, and the financial statements shall be comparative, presenting the amounts as of December 31 of the current year and the amounts as of the immediately preceding December 31. However, in the first year in which an insurer is required to file an audited financial report, the comparative data may be omitted.

HISTORY: Laws, 1991, ch. 550, § 4; Laws, 2007, ch. 369, § 3, eff from and after July 1, 2007.

Cross References — Audited financial report, defined, see § 83-5-102.

Scope of examination and report of independent certified public accountant, see § 83-5-109.

§ 83-5-104. Exemptions.

Every insurer shall be subject to Sections 83-5-101 through 83-5-113. Insurers having direct premiums written of less than One Million Dollars ($1,000,000.00) in any calendar year and less than one thousand (1,000) policyholders or certificate holders of directly written policies nationwide at the end of such calendar year shall be exempt from Sections 83-5-101 through 83-5-113 for such year unless the commissioner makes a specific finding that compliance is necessary for the commissioner to carry out statutory responsibilities, except that insurers having assumed premiums pursuant to contracts and/or treaties of reinsurance of One Million Dollars ($1,000,000.00) or more will not be so exempt.

Upon written application of any insurer, the commissioner may grant an exemption from compliance with Sections 83-5-101 through 83-5-113 if the commissioner finds, upon review of the application, that compliance with Sections 83-5-101 through 83-5-113 would constitute a financial or organizational hardship upon the insurer. An exemption may be granted at any time and from time to time for a specified period or periods. Within ten (10) days from a denial of an insurer's written request for an exemption from Sections 83-5-101 through 83-5-113, such insurer may request in writing a hearing on its application for an exemption. Such hearing shall be held in accordance with the rules and regulations of the Department of Insurance pertaining to administrative hearing procedures.

HISTORY: Laws, 1991, ch. 550, § 5; Laws, 2009, ch. 334, § 2, eff from and after Jan. 1, 2010.

§ 83-5-105. Extensions.

Extensions of the June 1 filing date may be granted by the commissioner for thirty-day periods upon showing by the insurer and its independent certified public accountant the reasons for requesting such extension and determination by the commissioner of good cause for an extension. The request for extension must be submitted in writing not less than ten (10) days prior to the due date in sufficient detail to permit the commissioner to make an informed decision with respect to the requested extension.

If an extension is granted, a similar extension of thirty (30) days is granted to the filing of Management's Report of Internal Control over Financial Reporting.

HISTORY: Laws, 1991, ch. 550, § 6; Laws, 2009, ch. 334, § 3, eff from and after Jan. 1, 2010.

Cross References — Management's Report of Internal Control over Financial Reporting defined, see § 83-5-102.

§ 83-5-106. Designation of independent certified public accountants.

Each insurer required to file an annual audited financial report must, within sixty (60) days after becoming subject to such requirement, register with the commissioner in writing the name and address of the independent certified public accountant or accounting firm (generally referred to here as the "accountant") retained to conduct the annual audit set forth in Section 83-5-101. Insurers not previously retaining an independent certified public accountant shall register the name and address of their retained certified public accountant not less than six (6) months before the date when the first audited financial report is to be filed.

The insurer shall obtain a letter from such accountant, and file a copy with the commissioner stating that the accountant is aware of the provisions of the insurance code and the rules and regulations of the Department of Insurance that relate to accounting and financial matters and affirming that he will express his opinion on the financial statements in terms of their conformity to the statutory accounting practices prescribed or otherwise permitted by the department, specifying such exceptions as he may believe appropriate.

If an accountant who was the accountant for the immediately preceding filed audited financial report is dismissed or resigns, the insurer shall within five (5) business days notify the Department of Insurance of this event. The insurer shall also furnish the commissioner with a separate letter within ten (10) business days of the above notification stating whether in the twenty-four (24) months preceding such event there were any disagreements with the former accountant on any matter of accounting principles or practices, financial statement disclosure, or auditing scope or procedure; which disagreements, if not resolved to the satisfaction of the former accountant, would have caused him to make reference to the subject matter of the disagreement in connection with his opinion. The disagreements required to be reported in response to this section include both those resolved to the former accountant's satisfaction and those not resolved to the former accountant's satisfaction. Disagreements contemplated by this section are those that occur at the decision-making level, i.e., between personnel of the insurer responsible for presentation of its financial statements and personnel of the accounting firm responsible for rendering its report. The insurer shall also in writing request such former accountant to furnish a letter addressed to the insurer stating whether the accountant agrees with the statements contained in the insurer's letter and, if not, stating the reasons for which he does not agree; and the insurer shall furnish such responsive letter from the former accountant to the commissioner together with its own.

HISTORY: Laws, 1991, ch. 550, § 7, eff from and after July 1, 1991.

§ 83-5-107. Qualifications of independent certified public accountant.

(1) The commissioner shall not recognize a person or firm as a qualified independent certified public accountant if the person or firm:

(a) Is not in good standing with the American Institute of Certified Public Accountants and in all states in which the accountant is licensed to practice, or, for a Canadian or British company, that is not a chartered accountant; or

(b) Has either directly or indirectly entered into an agreement of indemnity or release from liability, collectively referred to as indemnification, with respect to the audit of the insurer.

(2) Except as otherwise provided herein, the commissioner shall recognize an independent certified public accountant as qualified as long as he or she conforms to the standards of his or her profession, as contained in the Code of Professional Ethics of the American Institute of Certified Public Accountants and rules and regulations and code of ethics and rules of professional conduct of the appropriate state board of public accountancy, or similar code.

(3) A qualified independent certified public accountant may enter into an agreement with an insurer to have disputes relating to an audit resolved by mediation or arbitration. However, in the event of a delinquency proceeding commenced against the insurer under Sections 83-23-1 through 83-23-9, the mediation or arbitration provisions shall operate at the option of the statutory successor.

(4) The lead or coordinating audit partner having primary responsibility for the audit may not act in that capacity for more than five (5) consecutive years. The person shall be disqualified from acting in that or a similar capacity for the same company or its insurance subsidiaries or affiliates for a period of five (5) consecutive years. An insurer may make application to the commissioner for relief from the above rotation requirement on the basis of unusual circumstances. This application should be made at least thirty (30) days before the end of the calendar year. The commissioner may consider the following factors in determining if the relief should be granted:

(a) Number of partners, expertise of the partners or the number of insurance clients in the currently registered firm;

(b) Premium volume of the insurer; or

(c) Number of jurisdictions in which the insurer transacts business.

The insurer shall file, with its annual statement filing, the approval for relief with the states that it is licensed or doing business.

(5) The commissioner shall neither recognize as a qualified independent certified public accountant, nor accept an annual audited financial report, prepared in whole or in part by, a natural person who:

(a) Has been convicted of fraud, bribery, a violation of the Racketeer Influenced and Corrupt Organizations Act, 18 USCS Sections 1961-1968, or any dishonest conduct or practices under federal or state law;

(b) Has been found to have violated the insurance laws of this state with respect to any previous reports submitted under this rule; or

(c) Has demonstrated a pattern or practice of failing to detect or disclose material information in previous reports filed under the provisions of Sections 83-5-101 through 83-5-113.

(6) The commissioner may hold a hearing to determine whether an independent certified public accountant is qualified and, considering the evidence presented, may rule that the accountant is not qualified for purposes of expressing his opinion on the financial statements in the annual audited financial report made pursuant to Sections 83-5-101 through 83-5-113 and require the insurer to replace the accountant with another whose relationship with the insurer is qualified within the meaning of this section.

(7) The commissioner shall not recognize as a qualified independent certified public accountant, nor accept an annual audited financial report, prepared in whole or in part by an accountant who provides to an insurer, contemporaneously with the audit, the following nonaudit services:

(a) Bookkeeping or other services related to the accounting records or financial statements of the insurer;

(b) Financial information systems design and implementation;

(c) Appraisal or valuation services, fairness opinions, or contribution-in-kind reports;

(d) Actuarially oriented advisory services involving the determination of amounts recorded in the financial statements. The accountant may assist an insurer in understanding the methods, assumptions and inputs used in the determination of amounts recorded in the financial statement only if it is reasonable to conclude that the services provided will not be subject to audit procedures during an audit of the insurer's financial statements. An accountant's actuary may also issue an actuarial opinion or certification ("opinion") on an insurer's reserves if the following conditions have been met:

(i) Neither the accountant nor the accountant's actuary has performed any management functions or made any management decisions;

(ii) The insurer has competent personnel (or engages a third-party actuary) to estimate the reserves for which management takes responsibility; and

(iii) The accountant's actuary tests the reasonableness of the reserves after the insurer's management has determined the amount of the reserves;

(e) Internal audit outsourcing services;

(f) Management functions or human resources;

(g) Broker or dealer, investment adviser, or investment banking services;

(h) Legal services or expert services unrelated to the audit; or

(i) Any other services that the commissioner determines are impermissible.

In general, the principles of independence with respect to services provided by the qualified independent certified public accountant are largely predicated on three (3) basic principles, violations of which would impair the accountant's independence. The principles are that the accountant cannot function in the role of management, cannot audit his or her own work, and cannot serve in an advocacy role for the insurer.

(8) A qualified independent certified public accountant who performs the audit may engage in other nonaudit services, including tax services, that are not described in subsection (7) or that do not conflict with subsection (7), only if the activity is approved in advance by the audit committee, in accordance with subsection (9).

(9) All auditing services and nonaudit services provided to an insurer by the qualified independent certified public accountant of the insurer shall be preapproved by the audit committee. The preapproval requirement is waived with respect to nonaudit services if the insurer is a SOX Compliant Entity or a direct or indirect wholly owned subsidiary of a SOX Compliant Entity or:

(a) The aggregate amount of all such nonaudit services provided to the insurer constitutes not more than five percent (5%) of the total amount of fees paid by the insurer to its qualified independent certified public accountant during the fiscal year in which the nonaudit services are provided;

(b) The services were not recognized by the insurer at the time of the engagement to be nonaudit services; and

(c) The services are promptly brought to the attention of the audit committee and approved prior to the completion of the audit by the audit committee or by one or more members of the audit committee who are the members of the board of directors to whom authority to grant such approvals has been delegated by the audit committee.

(10) The audit committee may delegate to one or more designated members of the audit committee the authority to grant the preapprovals required by subsection (9). The decisions of any member to whom this authority is delegated shall be presented to the full audit committee at each of its scheduled meetings.

(11) The commissioner shall not recognize an independent certified public accountant as qualified for a particular insurer if a member of the board, president, chief executive officer, controller, chief financial officer, chief accounting officer, or any person serving in an equivalent position for that insurer, was employed by the independent certified public accountant and participated in the audit of that insurer during the one-year period preceding the date that the most current statutory opinion is due. This section shall only apply to partners and senior managers involved in the audit. An insurer may make application to the commissioner for relief from the above requirement on the basis of unusual circumstances.

The insurer shall file, with its annual statement filing, the approval for relief with the states that it is licensed or doing business.

HISTORY: Laws, 1991, ch. 550, § 8; Laws, 2003, ch. 420, § 1; Laws, 2007, ch. 369, § 4; Laws, 2009, ch. 334, § 4, eff from and after Jan. 1, 2010.

Cross References — Accountant's letter of qualification, see § 83-5-112.

RESEARCH REFERENCES

Am. Jur.
1 Am. Jur. Pl & Pr Forms, Rev, Accountants, Form 21.2.

§ 83-5-108. Consolidated or combined audits.

An insurer may make written application to the commissioner for approval to file audited consolidated or combined financial statements in lieu of separate annual audited financial statements if the insurer is part of a group of insurance companies which utilizes a pooling or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and such insurer cedes all of its direct and assumed business to the pool. In such cases, a columnar consolidating or combining work sheet shall be filed with the report, as follows:

(a) Amounts shown on the consolidated or combined audited financial report shall be shown on the work sheet.

(b) Amounts for each insurer subject to this section shall be stated separately.

(c) Noninsurance operations may be shown on the work sheet on a combined or individual basis.

(d) Explanations of consolidating and eliminating entries shall be included.

(e) A reconciliation shall be included of any differences between the amounts shown in the individual insurer columns of the work sheet and comparable amounts shown on the annual statements of the insurers.

HISTORY: Laws, 1991, ch. 550, § 9, eff from and after July 1, 1991.

§ 83-5-109. Scope of examination and report of independent certified public accountant.

Financial statements furnished pursuant to Section 83-5-103 shall be audited by an independent certified public accountant. The audit of the insurer's financial statements shall be conducted in accordance with generally accepted auditing standards. The independent certified public accountant should obtain an understanding of internal control sufficient to plan the audit. To the extent required by generally accepted auditing standards, for those insurers required to file a Management's Report of Internal Control over Financial Reporting pursuant to Section 83-5-123, the independent certified public accountant should consider (as that term is defined in Statement on Auditing Standards No. 102, "Defining Professional Requirements in Statements on Auditing Standards," or its replacement) the most recently available report in planning and performing the audit of the statutory financial statements. Consideration shall be given to the procedures illustrated in the Financial Condition Examiners Handbook promulgated by the National Association of Insurance Commissioners as the independent certified public accountant deems necessary.

HISTORY: Laws, 1991, ch. 550, § 10; Laws, 2009, ch. 334, § 5, eff from and after Jan. 1, 2010.

§ 83-5-110. Notification of adverse financial condition.

The insurer required to furnish the annual audited financial report shall require the independent certified public accountant to report in writing within five (5) business days to the board of directors or its audit committee any reasonable belief by the independent certified public accountant that the insurer has materially misstated its financial condition as reported to the commissioner as of the balance sheet date currently under examination or that the insurer does not meet the minimum capital and surplus requirement of the state insurance laws as of that date. An insurer who has received a report pursuant to this paragraph shall forward a copy of the report to the commissioner within five (5) business days of receipt of such report and shall provide the independent certified public accountant making the report with evidence of the report being furnished to the commissioner. If the independent certified public accountant fails to receive such evidence within the required five (5) business days period, the independent certified public accountant shall furnish to the commissioner a copy of its report within the next five (5) business days.

No independent public accountant shall be liable in any manner to any person for any statement made in connection with the above paragraph if such statement is made in good faith in compliance with the above paragraph.

If the accountant, subsequent to the date of the audited financial report filed pursuant to Sections 83-5-101 through 83-5-113, becomes aware of facts which might have affected his report, the accountant is obligated to take such action as prescribed in Volume I, Section AU 561 of the Professional Standards of the American Institute of Certified Public Accountants.

HISTORY: Laws, 1991, ch. 550, § 11, eff from and after July 1, 1991.

§ 83-5-111. Report on significant deficiencies in internal controls.

In addition to the annual audited financial report, each insurer shall furnish the commissioner with a written communication as to any unremediated material weaknesses in its internal control over financial reporting noted during the audit. Such communication shall be prepared by the accountant within sixty (60) days after the filing of the annual audited financial report, and shall contain a description of any unremediated material weakness (as the term material weakness is defined by Statement on Auditing Standard No. 115, "Communication of Internal Control Related Matters Identified in an Audit," or its replacement) as of December 31 immediately preceding in the insurer's internal control over financial reporting noted by the accountant during the course of their audit of the financial statements. If no unremediated material weaknesses were noted, the communication should so state.

The insurer is required to provide a description of remedial actions taken or proposed to correct unremediated material weaknesses if the actions are not described in the accountant's communication.

HISTORY: Laws, 1991, ch. 550, § 12; Laws, 2009, ch. 334, § 6, eff from and after Jan. 1, 2010.

§ 83-5-112. Accountant's letter of qualifications.

The accountant shall furnish the insurer in connection with, and for inclusion in, the filing of the annual audited financial report, a letter stating:

(a) That he is independent with respect to the insurer and conforms to the standards of his profession as contained in the Code of Professional Ethics and pronouncements of the American Institute of Certified Public Accountants and the rules of professional conduct of the appropriate state board of public accountancy, or similar code.

(b) The background and experience in general, and the experience in audits of insurers of the staff assigned to the engagement and whether each is an independent certified public accountant. Nothing within this section shall be construed as prohibiting the accountant from utilizing such staff as he deems appropriate where such use is consistent with the standards prescribed by generally accepted auditing standards.

(c) That the accountant understands the annual audited financial report and his opinion thereon will be filed in compliance with this section and that the commissioner will be relying on this information in the monitoring and regulating of the financial position of insurers.

(d) That the accountant consents to the requirements of Section 83-5-113 and that the accountant consents and agrees to make available for review by the commissioner, his designee or his appointed agent, the work papers, as defined in Section 83-5-113.

(e) A representation that the accountant is properly licensed by an appropriate state licensing authority and that he is a member in good standing in the American Institute of Certified Public Accountants.

(f) A representation that the accountant is in compliance with the requirements of Section 83-5-107.

HISTORY: Laws, 1991, ch. 550, § 13, eff from and after July 1, 1991.

§ 83-5-113. Definition, availability and maintenance of certified public accountant work papers.

Work papers are the records kept by the independent certified public accountant of the procedures followed, the tests performed, the information obtained and the conclusion reached pertinent to his examination of the financial statements of an insurer. Work papers, accordingly, may include audit planning documentation, work programs, analyses, memoranda, letters of confirmation and representation, abstracts of company documents and schedules or commentaries prepared or obtained by the independent certified public accountant in the course of his examination of the financial statements of an insurer and which support his opinion thereof.

Every insurer required to file an audited financial report pursuant to Sections 83-5-101 through 83-5-113 shall require the accountant to make available for review by department examiners all work papers prepared in the conduct of his examination and any communications related to the audit between the accountant and the insurer, at the offices of the insurer, at the Department of Insurance or at any other reasonable place designated by the commissioner. The insurer shall require that the accountant retain the audit work papers and communications until the Department of Insurance has filed a report on examination covering the period of the audit, but no longer than seven (7) years from the date of the audit report.

In the conduct of the aforementioned periodic review by the department examiners, it shall be agreed that photocopies of pertinent audit work papers may be made and retained by the department. Such reviews by the department examiners shall be considered investigations and all work papers and communications obtained during the course of such investigations shall be afforded the same confidentiality as other examination work papers generated by the department.

HISTORY: Laws, 1991, ch. 550, § 13; Laws, 2009, ch. 334, § 7, eff from and after Jan. 1, 2010.

§ 83-5-114. Severability.

If any section or portion of a section of Sections 83-5-101 through 83-5-113 or its applicability to any person or circumstance is held invalid by a court, the remainder of this chapter or the applicability of the provision to other persons or circumstances shall not be affected.

HISTORY: Laws, 2009, ch. 334, § 12, eff from and after Jan. 1, 2010.

§ 83-5-115. Authority of Department of Insurance to determine method of calculating values of stocks, bonds and other sureties held by insurer.

(1) All bonds or other evidences of debt having a fixed term and rate of interest held by an insurer, if secured and not in default as to principal or interest, may be valued as follows:

(a) If purchased at par, at the par value.

(b) If purchased above or below par, on the basis of the purchase price adjusted to bring the value to par at maturity and to yield in the meantime the effective rate of interest at which the purchase was made, or in lieu of this method, according to any accepted method of valuation approved by the Department of Insurance.

(c) Purchase price shall not be taken at a higher figure than the actual market value at the time of purchase, plus actual brokerage, transfer, postage or express charges paid in the acquisition of the securities.

(2) The Department of Insurance shall have full discretion in determining the method of calculating values according to the rules set forth in this section, but no method or valuation shall be inconsistent with any applicable valuation or method used by insurers in general or any method formulated or approved by the National Association of Insurance Commissioners or its successor organization.

HISTORY: Laws, 1994, ch. 313, § 1, eff from and after July 1, 1994.

Cross References — Methods of valuation which may be used to calculate values of stocks, bonds and other sureties held by insurer, see § 83-5-117.

§ 83-5-117. Methods of valuation which may be used to calculate values of stocks, bonds and other sureties held by insurer.

(1) Securities, other than those referred to in 83-5-115, held by an insurer shall be valued, in the discretion of the Department of Insurance, at their market value or at their appraised value or at prices determined by it as representing their fair market value.

(2) Preferred or guaranteed stocks or shares while paying full dividends may be carried at a fixed value in lieu of market value, at the discretion of the Department of Insurance and in accordance with the method of valuation as it may approve.

(3) Stock of a subsidiary corporation of an insurer shall not be valued at an amount in excess of the net value thereof as based upon those assets only of the subsidiary which would be eligible under either Section 83-6-2 or 83-19-51 for investment of the funds of the insurer directly.

(4) No valuations under this section shall be inconsistent with any applicable valuation or method formulated or approved by the National Association of Insurance Commissioners or its successor organization.

HISTORY: Laws, 1994, ch. 313, § 2, eff from and after July 1, 1994.

§ 83-5-119. Requirements for audit committees.

Every insurer required to file an annual audited financial report pursuant to this section shall designate a group of individuals as constituting its audit committee. The audit committee of an entity that controls an insurer may be deemed to be the insurer's audit committee for purposes of this section at the election of the controlling person.

This section shall not apply to foreign or alien insurers licensed in this state or an insurer that is a SOX Compliant Entity or a direct or indirect wholly owned subsidiary of a SOX Compliant Entity.

(a) The audit committee shall be directly responsible for the appointment, compensation and oversight of the work of any accountant (including resolution of disagreements between management and the accountant regarding financial reporting) for the purpose of preparing or issuing the audited financial report or related work pursuant to this section. Each accountant shall report directly to the audit committee.

(b) Each member of the audit committee shall be a member of the board of directors of the insurer or a member of the board of directors of an entity elected pursuant to paragraph (e) and Section 83-5-102(h).

(c) In order to be considered independent for purposes of this section, a member of the audit committee may not, other than in his or her capacity as a member of the audit committee, the board of directors, or any other board committee, accept any consulting, advisory or other compensatory fee from the entity or be an affiliated person of the entity or any subsidiary thereof. However, if law requires board participation by otherwise nonindependent members, that law shall prevail and such members may participate in the audit committee and be designated as independent for audit committee purposes, unless they are an officer or employee of the insurer or one (1) of its affiliates.

(d) If a member of the audit committee ceases to be independent for reasons outside the member's reasonable control, that person, with notice by the responsible entity to the state, may remain an audit committee member of the responsible entity until the earlier of the next annual meeting of the responsible entity or one (1) year from the occurrence of the event that caused the member to be no longer independent.

(e) To exercise the election of the controlling person to designate the audit committee for purposes of this section, the ultimate controlling person shall provide written notice to the commissioners of the affected insurers. Notification shall be made timely prior to the issuance of the statutory audit report and include a description of the basis for the election. The election can be changed through notice to the commissioner by the insurer, which shall include a description of the basis for the change. The election shall remain in effect for perpetuity, until rescinded.

(f)(i) The audit committee shall require the accountant that performs for an insurer any audit required by this section to timely report to the audit committee in accordance with the requirements of Statement on Auditing Standard No. 114, The Auditor's Communication With Those Charged With Governance or its replacement, including:

1. All significant accounting policies and material permitted practices;

2. All material alternative treatments of financial information within statutory accounting principles that have been discussed with management officials of the insurer, ramifications of the use of the alternative disclosures and treatments, and the treatment preferred by the accountant; and

3. Other material written communications between the accountant and the management of the insurer, such as any management letter or schedule of unadjusted differences.

(ii) If an insurer is a member of an insurance holding company system, the reports required by paragraph (f)(i) may be provided to the audit committee on an aggregate basis for insurers in the holding company system, provided that any substantial differences among insurers in the system are identified to the audit committee.

(g) The proportion of independent audit committee members shall meet or exceed the following criteria:

Prior Calendar Year Direct Written and Assumed Premiums

$0 - $300,000,000	**Over $300,000,000 - $500,000,000**	**Over $500,000,000**
No minimum requirements. See also Notes A and B.	Majority (50% or more) of members shall be independent. See also Notes A and B.	Supermajority of members (75% or more) shall be independent. See also Note A.

Note A: The commissioner has authority afforded by state law to require the entity's board to enact improvements to the independence of the audit committee membership if the insurer is in a RBC action level event, meets one or more of the standards of an insurer deemed to be in hazardous financial condition, or otherwise exhibits qualities of a troubled insurer.

Note B: All insurers with less than Five Hundred Million Dollars ($500,000,000.00) in prior calendar year direct written and assumed premiums are encouraged to structure their audit committees with at least a supermajority of independent audit committee members.

Note C: Prior calendar year direct written and assumed premiums shall be the combined total of direct premiums and assumed premiums from nonaffiliates for the reporting entities.

(h) An insurer with direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program less than Five Hundred Million Dollars ($500,000,000.00), may make application to the commissioner for a waiver from the requirements of this section based upon hardship. The insurer shall file, with its annual statement filing, the approval for relief from the requirements of this section with the states that it is licensed or doing business.

(i) An insurer or group of insurers that is not required to have independent audit committee members or only a majority of independent audit committee members (as opposed to a supermajority) because the total written and assumed premium is below the threshold and subsequently becomes subject to one (1) of the independence requirements due to changes in premium shall have one (1) year following the year the threshold is exceeded to comply with the independence requirements. Likewise, an insurer that becomes subject to one (1) of the independence requirements as a result of a business combination shall have one (1) calendar year following the date of acquisition or combination to comply with the independence requirements.

(j) The audit committee of an insurer or group of insurers shall be responsible for overseeing the insurer's internal audit function and granting the person or persons performing the function suitable authority and resources to fulfill their responsibilities if required by Section 83-5-120.

HISTORY: Laws, 2009, ch. 334, § 8, eff from and after Jan. 1, 2010; Laws, 2019, ch. 326, § 2, eff from and after January 1, 2020.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected typographical errors in the first and second columns of the table in subsection (g) by substituting "See also Notes A and B" for "See also Note A and B." The Joint Committee ratified the correction at its July 22, 2010, meeting.

§ 83-5-120. Internal audit function requirements.

(1) **Exemption.** An insurer is exempt from the requirements of this section if:

(a) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than Five Hundred Million Dollars ($500,000,000.00); and

(b) If the insurer is a member of a group of insurers, the group has annual direct written and unaffiliated assumed premium, including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than One Billion Dollars ($1,000,000,000.00).

Note: An insurer or group of insurers exempt from the requirements of this section is encouraged, but not required, to conduct a review of the insurer business type, sources of capital, and other risk factors to determine whether an internal audit function is warranted. The potential benefits of an internal audit function should be assessed and compared against the estimated costs.

(2) **Function.** The insurer or group of insurers shall establish an internal audit function providing independent, objective and reasonable assurance to the audit committee and insurer management regarding the insurer's governance, risk management and internal controls. This assurance shall be provided by performing general and specific audits, reviews and tests and by employing other techniques deemed necessary to protect assets, evaluate control effectiveness and efficiency, and evaluate compliance with policies and regulations.

(3) **Independence.** In order to ensure that internal auditors remain objective, the internal audit function must be organizationally independent. Specifically, the internal audit function will not defer ultimate judgment on audit matters to others, and shall appoint an individual to head the internal audit function who will have direct and unrestricted access to the board of directors. Organizational independence does not preclude dual-reporting relationships.

(4) **Reporting.** The head of the internal audit function shall report to the audit committee regularly, but no less than annually, on the periodic audit plan, factors that may adversely impact the internal audit function's independence or effectiveness, material findings from completed audits and the appropriateness of corrective actions implemented by management as a result of audit findings.

(5) **Additional requirements.** If an insurer is a member of an insurance holding company system or included in a group of insurers, the insurer may satisfy the internal audit function requirements set forth in this section at the ultimate controlling parent level, an intermediate holding company level or the individual legal entity level.

HISTORY: Laws, 2019, ch. 326, § 3, eff from and after January 1, 2020.

§ 83-5-121. Conduct of insurer in connection with the preparation of required reports and documents.

(1) No director or officer of an insurer shall, directly or indirectly:

(a) Make or cause to be made a materially false or misleading statement to an accountant in connection with any audit, review or communication required under this section; or

(b) Omit to state, or cause another person to omit to state, any material fact necessary in order to make statements made, in light of the circumstances under which the statements were made, not misleading to an accountant in connection with any audit, review or communication required under this section.

(2) No officer or director of an insurer, or any other person acting under the direction thereof, shall directly or indirectly take any action to coerce, manipulate, mislead or fraudulently influence any accountant engaged in the performance of an audit pursuant to this section if that person knew or should have known that the action, if successful, could result in rendering the insurer's financial statements materially misleading.

(3) For purposes of subsection (2) of this section, actions that, "if successful, could result in rendering the insurer's financial statements materially misleading" include, but are not limited to, actions taken at any time with respect to the professional engagement period to coerce, manipulate, mislead or fraudulently influence an accountant:

(a) To issue or reissue a report on an insurer's financial statements that is not warranted in the circumstances (due to material violations of statutory accounting principles prescribed by the commissioner, generally accepted auditing standards, or other professional or regulatory standards);

(b) Not to perform audit, review or other procedures required by generally accepted auditing standards or other professional standards;

(c) Not to withdraw an issued report; or

(d) Not to communicate matters to an insurer's audit committee.

HISTORY: Laws, 2009, ch. 334, § 9, eff from and after Jan. 1, 2010.

§ 83-5-123. Management's report of internal control over financial reporting.

(1) Every insurer required to file an audited financial report pursuant to this section that has annual direct written and assumed premiums, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, of Five Hundred Million Dollars ($500,000,000.00) or more shall prepare a report of the insurer's or group of insurers' internal control over financial reporting, as these terms are defined in Section 83-5-102. The report shall be filed with the commissioner along with the Communication of Internal Control Related Matters Noted in an Audit described under Section 83-5-111. Management's Report of Internal Control over Financial Reporting shall be as of December 31 immediately preceding. Foreign or alien insurers required to file Management's Report of Internal Control over Financial Reporting in another state are exempt from filing the Management's Report of Internal Control over Financial Reporting in this state provided the other state has substantially similar reporting requirements and the Management's Report of Internal Control over Financial Reporting is filed with the commissioner of the other state within the time specified. An insurer or group of insurers that is not required to file Management's Report of Internal Control over Financial Reporting because the total written premium is below the threshold and subsequently becomes subject to the reporting requirements shall have two (2) years following the year the threshold is exceeded to file a report. Likewise, an insurer acquired in a business combination shall have two (2) calendar years following the date of acquisition or combination to comply with the reporting requirements.

(2) Notwithstanding the premium threshold in subsection (1), the commissioner may require an insurer to file Management's Report of Internal Control over Financial Reporting if the insurer is in any RBC level event, or meets any one or more of the standards of an insurer deemed to be in hazardous financial condition as defined by regulation.

(3) An insurer or a group of insurers that is:

(a) Directly subject to Section 404;

(b) Part of a holding company system whose parent is directly subject to Section 404;

(c) Not directly subject to Section 404 but is a SOX Compliant Entity; or

(d) A member of a holding company system whose parent is not directly subject to Section 404 but is a SOX Compliant Entity;

may file its or its parent's Section 404 Report and an addendum in satisfaction of the requirements of this section provided that those internal controls of the insurer or group of insurers having a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements were included in the scope of the Section 404 Report. The addendum shall be a positive statement by management that there are no material processes with respect to the preparation of the insurer's or group of insurers' audited statutory financial statements excluded from the Section 404 Report. If there are internal controls of the insurer or group of insurers that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements and those internal controls were not included in the scope of the Section 404 Report, the insurer or group of insurers may either file (i) a report required pursuant to this section, or (ii) the Section 404 Report and a report required pursuant to this section for those internal controls that have a material impact on the preparation of the insurer's or group of insurers' audited statutory financial statements not covered by the Section 404 Report.

(4) Management's Report of Internal Control over Financial Reporting shall include:

(a) A statement that management is responsible for establishing and maintaining adequate internal control over financial reporting;

(b) A statement that management has established internal control over financial reporting and an assertion, to the best of management's knowledge and belief, after diligent inquiry, as to whether its internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles;

(c) A statement that briefly describes the approach or processes by which management evaluated the effectiveness of its Internal control over financial reporting;

(d) A statement that briefly describes the scope of work that is included and whether any internal controls were excluded;

(e) Disclosure of any unremediated material weaknesses in the internal control over financial reporting identified by management as of December 31 immediately preceding. Management is not permitted to conclude that the internal control over financial reporting is effective to provide reasonable assurance regarding the reliability of financial statements in accordance with statutory accounting principles if there is one or more unremediated material weaknesses in its internal control over financial reporting;

(f) A statement regarding the inherent limitations of internal control systems; and

(g) Signatures of the chief executive officer and the chief financial officer (or equivalent position/title).

(5) Management shall document and make available upon financial condition examination the basis upon which its assertions, required in subsection (4) above, are made. Management may base its assertions, in part, upon its review, monitoring and testing of internal controls undertaken in the normal course of its activities.

(a) Management shall have discretion as to the nature of the internal control framework used, and the nature and extent of documentation, in order to make its assertion in a cost-effective manner and, as such, may include assembly of or reference to existing documentation.

(b) Management's Report on Internal Control over Financial Reporting, required by subsection (1) above, and any documentation provided in support thereof during the course of a financial condition examination, shall be kept confidential by the state insurance department.

HISTORY: Laws, 2009, ch. 334, § 10, eff from and after Jan. 1, 2010.

Federal Aspects — Section 404 of the Sarbanes-Oxley Act of 2002, see 15 USCS § 7262.

§ 83-5-125. Canadian and British companies.

(1) In the case of Canadian and British insurers, the annual audited financial report shall be defined as the annual statement of total business on the form filed by such companies with their supervision authority duly audited by an independent chartered accountant.

(2) For such insurers, the letter required in Section 83-5-106 shall state that the accountant is aware of the requirements relating to the annual audited financial report filed with the commissioner pursuant to Section 83-5-101 and shall affirm that the opinion expressed is in conformity with those requirements.

HISTORY: Laws, 2009, ch. 334, § 11, eff from and after Jan. 1, 2010.

ARTICLE 3.

PERIODIC FINANCIAL EXAMINATIONS OF INSURERS.

Sec.
83-5-201. Purpose of sections 83-5-201 through 83-5-217.
83-5-203. Definitions.
83-5-205. Examination of insurers; examination of foreign or alien insurer; acceptance of examination report prepared by insurance department of another state; financial and market analysis review of all insurers.
83-5-207. Appointment of examiners; guidelines and procedures to be followed by examiner; insurers to facilitate examination; penalties for refusal to comply with request of examiner; power of examiners; authority of commissioner to hire examiners; company examined to pay cost of examination; authority of commissioner not limited.
83-5-209. Contents of examination report; filing of report; opportunity to respond to report; review of report by and order of commissioner; hearings; confidentiality of examination reports; disclosure of reports.
83-5-211. Appointment of examiners.
83-5-213. Compensation and expenses of examiner.
83-5-215. Reports to be furnished to State Tax Commission; Tax Commission not precluded from performing additional audits.
83-5-217. No cause of action against examiners; no cause of action against person providing information to examiner; statutory privilege or immunity not abridged; examiner's right to award of attorney fees in civil action.

§ 83-5-201. Purpose of sections 83-5-201 through 83-5-217.

The purpose of Sections 83-5-201 through 83-5-217 is to provide an effective and efficient system for examining the activities, operations, financial condition and affairs of all persons transacting the business of insurance in this state and all persons otherwise subject to the jurisdiction of the commissioner. Sections 83-5-201 through 83-5-217 are intended to enable the commissioner to adopt a flexible system of examinations which directs resources as may be deemed appropriate and necessary for the administration of the insurance and insurance related laws of this state.

HISTORY: Laws, 1992, ch. 319, § 1, eff from and after July 1, 1992.

RESEARCH REFERENCES

Practice References.

Business Law Monographs (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

Liability of Corporate Officers and Directors, William E. Knepper, Dan A. Bailey, Stacy R. Lane, Katharine B. Bowman, Michael R. Goodstein, Darius N. Kandawalla (Matthew Bender).

§ 83-5-203. Definitions.

The following terms as used in Sections 83-5-201 through 83-5-217 shall have the respective meanings hereinafter set forth:

(a) "Commissioner" means the Commissioner of Insurance.

(b) "Company" means any person engaging in or proposing or attempting to engage in any transaction or kind of insurance or surety business, and any person or group of persons who may otherwise be subject to the administrative, regulatory or taxing authority of the commissioner.

(c) "Department" means the Department of Insurance.

(d) "Examiner" means any individual or firm having been authorized by the commissioner to conduct an examination under Sections 83-5-201 through 83-5-217.

(e) "Insurer" means an insurer as the term is used in Section 83-5-1.

(f) "Person" means any individual, aggregation of individuals, trust, association, partnership or corporation, or any affiliate thereof.

HISTORY: Laws, 1992, ch. 319, § 2, eff from and after July 1, 1992.

§ 83-5-205. Examination of insurers; examination of foreign or alien insurer; acceptance of examination report prepared by insurance department of another state; financial and market analysis review of all insurers.

(1) The commissioner or any of his examiners may conduct an examination under Sections 83-5-201 through 83-5-217 of any company as often as the commissioner, in his or her sole discretion, deems appropriate but, at a minimum, shall conduct an examination of every insurer licensed in this state not less frequently than once every five (5) years. In scheduling and determining the nature, scope and frequency of the examinations, the commissioner shall consider such matters as the results of financial statement analyses and ratios, changes in management or ownership, actuarial opinions, reports of independent certified public accountants and other criteria as set forth in the

Examiners' Handbook adopted by the National Association of Insurance Commissioners and in effect when the commissioner exercises discretion under this section.

(2) For purposes of completing an examination of any company under Sections 83-5-201 through 83-5-217, the commissioner may examine or investigate any person, or the business of any person, insofar as such examination or investigation, in the sole discretion of the commissioner, is necessary or material to the examination of the company.

(3) In lieu of an examination under Sections 83-5-201 through 83-5-217 of any foreign or alien insurer licensed in this state, the commissioner may accept an examination report on the company as prepared by the insurance department for the company's state of domicile or port-of-entry state until January 1, 1994. Thereafter, such reports may only be accepted if (a) the insurance department was at the time of the examination accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program; or (b) the examination is performed under the supervision of an accredited insurance department or with the participation of one or more examiners who are employed by such an accredited state insurance department and who, after a review of the examination work papers and report, state under oath that the examination was performed in a manner consistent with the standards and procedures required by their insurance department.

(4) In addition to those examinations performed by the commissioner pursuant to subsection (1) of this section, the commissioner shall conduct financial and market analysis review of all insurers authorized to do business in this state and may conduct regulatory review of entities regulated by the department. The reviews may include the annual statement and the market conduct annual statement of the insurer or regulated entity reviewed, company financial reports rendered pursuant to good and acceptable accounting practices, results of insurance solvency standards testing as performed by the National Association of Insurance Commissioners, results of prior examinations and office reviews, management changes, consumer complaints, and such other relevant information as from time to time may be required by the commissioner.

(5) In lieu of conducting a financial or market analysis under this section of any foreign or alien insurer licensed in this state, the commissioner may rely upon the financial or market analysis conducted by the insurance department of the company's state of domicile or port-of-entry accredited under the National Association of Insurance Commissioners' Financial Regulation Standards and Accreditation Program.

(6) Every insurer or regulated entity shall produce and make freely accessible to the commissioner the accounts, records, documents and files in its possession or control. Failure by an insurer or regulated entity to supply information requested by the department during a course of financial or market analysis may subject the insurer or regulated entity to revocation or suspension of its license, or, in lieu thereof, a fine not to exceed Ten Thousand Dollars ($10,000.00) per occurrence.

HISTORY: Laws, 1992, ch. 319, § 3; Laws, 2012, ch. 364, § 1; Laws, 2013, ch. 416, § 1, eff from and after July 1, 2014.

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:
"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."
Cross References — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.
Additional authority to examine registered insurer or affiliate, see § 83-6-27.
Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.
Examination of domestic fraternal benefit societies, see § 83-29-45.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d Insurance §§ 35, 37.

§ 83-5-207. Appointment of examiners; guidelines and procedures to be followed by examiner; insurers to facilitate examination; penalties for refusal to comply with request of examiner; power of examiners; authority of commissioner to hire examiners; company examined to pay cost of examination; authority of commissioner not limited.

(1) Upon determining that an examination should be conducted, the commissioner or the commissioner's designee shall issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall observe those guidelines and procedures set forth in the Examiners' Handbook adopted by the National Association of Insurance Commissioners. The commissioner may also employ such other guidelines or procedures as the commissioner may deem appropriate.

(2) Every company or person from whom information is sought, its officers, directors and agents, must provide to the examiners appointed under subsection (1) timely, convenient and free access, at all reasonable hours at its offices, to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors, employees and agents of the company or person must facilitate the examination and aid in the examination, so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of or nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. Any such proceedings for suspension, revocation or refusal of any license or authority shall be conducted in accordance with Section 83-1-29, 83-5-17, 83-5-67, 83-5-83 or 83-21-13.

(3) The commissioner or any of his examiners shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and, upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court.

(4) When making an examination under Sections 83-5-201 through 83-5-217, the commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the cost of which shall be borne by the company which is the subject of the examination.

(5) Nothing contained in Sections 83-5-201 through 83-5-217 shall be construed to limit the commissioner's authority to terminate or suspend any examination in order to pursue other legal or regulatory action under the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.

(6) Nothing contained in Sections 83-5-201 through 83-5-217 shall be construed to limit the commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or company work papers or other documents or any other information discovered or developed during the course of any examination in the furtherance of any legal or regulatory action which the commissioner, in his or her sole discretion, may deem appropriate.

HISTORY: Laws, 1992, ch. 319, § 4; Laws, 1997, ch. 410, § 26, eff from and after July 1, 1997.

§ 83-5-209. Contents of examination report; filing of report; opportunity to respond to report; review of report by and order of commissioner; hearings; confidentiality of examination reports; disclosure of reports.

(1) All examination reports shall be comprised of only facts appearing upon the books, records or other documents of the company, its agents or other persons examined, or as ascertained from the testimony of its officers or agents or other persons examined concerning its affairs and such conclusions and recommendations as the examiners find reasonably warranted from the facts.

(2) No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the department a verified written report of examination under oath. Upon receipt of the verified report, the department shall transmit the report to the company examined, together with a notice which shall afford the company examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report.

(3) Within thirty (30) days of the end of the period allowed for the receipt of written submissions or rebuttals, the commissioner shall fully consider and

review the report, together with any written submissions or rebuttals and any relevant portions of examiner work papers and enter an order:

(a) Adopting the examination report as filed, or with modification or corrections. If the examination report reveals that the company is operating in violation of any law, regulation or prior order of the commissioner, the commissioner may order the company to take any action the commissioner considers necessary and appropriate to cure such violation; or

(b) Rejecting the examination report with directions to the examiners to reopen the examination for purposes of obtaining additional data, documentation or information and refiling in accordance with subsections (1) and (2) of this section; or

(c) Calling for an investigatory hearing with no less than twenty (20) days' notice to the company for purposes of obtaining additional documentation, data, information and testimony.

(4) All orders entered in accordance with subsection (3)(a) of this section shall be accompanied by findings and conclusions resulting from the commissioner's consideration and review of the examination report, relevant examiner work papers, and any written submissions or rebuttals. Any such order shall be considered a final administrative decision and may be appealed under the Mississippi Administrative Procedures Act and shall be served upon the company by certified mail, together with a copy of the adopted examination report. Within thirty (30) days of the issuance of the adopted report, the company shall file affidavits executed by each of its directors stating under oath that they have received a copy of the adopted report and related orders.

(5) Any hearing conducted under subsection (3)(c) of this section by the commissioner or authorized representative shall be conducted as a nonadversarial confidential investigatory proceeding as necessary for the resolution of any inconsistencies, discrepancies or disputed issues apparent upon the face of the filed examination report or raised by or as a result of the commissioner's review of relevant work papers or by the written submission or rebuttal of the company. Within twenty (20) days of the conclusion of any such hearing, the commissioner shall enter an order in accordance with subsection (3)(a) of this section.

(a) The commissioner shall not appoint an examiner as an authorized representative to conduct the hearing. The hearing shall proceed expeditiously with discovery by the company limited to examiner work papers which tend to substantiate any assertions set forth in any written submission or rebuttal. The commissioner or his representative may issue subpoenas for the attendance of any witnesses or the production of any documents deemed relevant to the investigation whether under the control of the department, the company or other persons. The documents produced shall be included in the record, and testimony taken by the commissioner or his representative shall be under oath and preserved for the record.

Nothing contained in this section shall require the department to disclose any information or records which would indicate or show the existence or content of any investigation or activity of a criminal justice agency.

(b) The hearing shall proceed with the commissioner or his representative posing questions to the persons subpoenaed. Thereafter, the company and the department may present testimony relevant to the investigation. Cross-examination shall be conducted only by the commissioner or his representative. The company and the department shall be permitted to make closing statements and may be represented by counsel of their choice.

(6)(a) Upon the adoption of the examination report under subsection (3)(a) of this section, the commissioner shall continue to hold the content of the examination report as private and confidential information for a period of ten (10) days except to the extent provided in subsection (2) of this section. Thereafter, the commissioner may open the report for public inspection so long as no court of competent jurisdiction has stayed its publication.

(b) Nothing contained in Sections 83-5-201 through 83-5-217 shall prevent or be construed as prohibiting the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or country, or to law enforcement officials of this or any other state or agency of the federal government at any time, so long as such agency or office receiving the report or matters relating thereto agrees in writing to hold it confidential and in a manner consistent with Sections 83-5-201 through 83-5-217.

(c) If the commissioner determines that regulatory action is appropriate as a result of any examination, he may initiate any proceedings or actions as provided by law.

(7)(a)(i) Except as provided in subsection (6) and in this subsection (7), documents, materials or other information, including, but not limited to, all working papers, and copies thereof, created, produced or obtained by or disclosed to the commissioner or any other person in the course of an examination made under Sections 83-5-201 through 83-5-217, or in the course of analysis by the commissioner of the financial condition or market conduct of a company, shall be confidential by law and privileged, shall not be subject to the Mississippi Public Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(ii) Documents, materials or other information, including, but not limited to, all working papers, and copies thereof, in the possession or control of the National Association of Insurance Commissioners and its affiliates and subsidiaries shall be confidential by law and privileged, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action, if they are:

1. Created, produced or obtained by or disclosed to the National Association of Insurance Commissioners and its affiliates and subsidiaries in the course of the National Association of Insurance Commis-

sioners and its affiliates and subsidiaries assisting an examination made under Sections 83-5-201 through 83-5-217, or the laws of another state or jurisdiction that is substantially similar to Sections 83-5-201 through 83-5-217, or assisting a commissioner in the analysis of the financial condition or market conduct of a company; or

2. Disclosed to the National Association of Insurance Commissioners and its affiliates and subsidiaries under paragraph (c) of this subsection by a commissioner.

(b) Neither the commissioner nor any person who received the documents, material or other information while acting under the authority of the commissioner, including the National Association of Insurance Commissioners and its affiliates and subsidiaries, shall be permitted to testify in any private civil action concerning any confidential documents, materials or information subject to paragraph (a) of this subsection.

(c) In order to assist in the performance of the commissioner's duties, the commissioner:

(i) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to paragraph (a) of this subsection, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material, communication or other information;

(ii) May receive documents, materials, communications or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(iii) May enter into agreements governing the sharing and use of information consistent with this subsection.

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in paragraph (c) of this subsection.

(e) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this subsection shall be available and enforced in any proceeding in, and in any court of, this state.

(f) For the purposes of this subsection, the terms "department," "insurance department," "law enforcement agency," "regulatory agency," and the "National Association of Insurance Commissioners" include, but are not limited to, their employees, agents, consultants and contractors.

HISTORY: Laws, 1992, ch. 319, § 5; Laws, 2013, ch. 416, § 2, eff from and after July 1, 2014.

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:
"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."
Cross References — Mississippi Public Records Act, see § 25-61-1 et seq.

§ 83-5-211. Appointment of examiners.

(1) No examiner may be appointed by the commissioner if such examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under Sections 83-5-201 through 83-5-217. This section shall not be construed to automatically preclude an examiner from being:

(a) A policyholder or claimant under an insurance policy;

(b) A grantor of a mortgage or similar instrument on the examiner's residence to a regulated entity if done under customary terms and in the ordinary course of business;

(c) An investment owner in shares of regulated diversified investment companies; or

(d) A settlor or beneficiary of a "blind trust" into which any otherwise impermissible holdings have been placed.

(2) Notwithstanding the requirements of this section the commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants or other similar individuals who are independently practicing their professions, even though such persons may from time to time be similarly employed or retained by persons subject to examination under Sections 83-5-201 through 83-5-217.

HISTORY: Laws, 1992, ch. 319, § 6, eff from and after July 1, 1992.

§ 83-5-213. Compensation and expenses of examiner.

The compensation and expense of such examiner shall not exceed that approved by the National Association of Insurance Commissioners for all examiners on such examinations unless approved by the commissioner. An itemized account of such charges shall be submitted to and approved by the commissioner.

HISTORY: Laws, 1992, ch. 319, § 7; Laws, 1995, ch. 306, § 1, eff from and after passage (approved March 8, 1995).

§ 83-5-215. Reports to be furnished to State Tax Commission; Tax Commission not precluded from performing additional audits.

The results of audits performed hereunder by the commissioner shall be furnished to the State Tax Commission within thirty (30) days of completion.

Nothing herein shall be construed to prohibit the State Tax Commission from performing such additional audits or verifications as it may deem necessary to ensure the proper payment of taxes.

HISTORY: Laws, 1992, ch. 319, § 8, eff from and after July 1, 1992.

Editor's Notes — Section 27-3-4 provides that the terms "'Mississippi State Tax Commission,' 'State Tax Commission,' 'Tax Commission' and 'commission' appearing in the laws of this state in connection with the performance of the duties and functions by the Mississippi State Tax Commission, the State Tax Commission or Tax Commission shall mean the Department of Revenue."

§ 83-5-217. No cause of action against examiners; no cause of action against person providing information to examiner; statutory privilege or immunity not abridged; examiner's right to award of attorney fees in civil action.

(1) No cause of action shall arise, nor shall any liability be imposed against the commissioner, the commissioner's authorized representatives or any examiner appointed by the commissioner for any statements made or conduct performed in good faith while carrying out Sections 83-5-201 through 83-5-217.

(2) No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the commissioner or the commissioner's authorized representative or examiner pursuant to an examination made under Sections 83-5-201 through 83-5-217 if such act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(3) This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in subsection (1) of this section.

(4) A person identified in subsection (1) of this section shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out Sections 83-5-201 through 83-5-217 and the party bringing the action was not substantially justified in doing so. For purposes of this section, a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

HISTORY: Laws, 1992, ch. 319, § 9, eff from and after July 1, 1992.

ARTICLE 4.

"INSURABLE INTEREST" REQUIREMENTS.

Sec.
83-5-251. Procurer of insurance must have insurable interest; insurable interest defined; insurer reliance on applicant's representations; insurable interest of charitable, etc. organization.

Sec.	
83-5-253.	Consent of insured required in certain cases.
83-5-255.	Enforcement by commissioner.
83-5-257.	Provisions cumulative of existing statutory and common law.

§ 83-5-251. Procurer of insurance must have insurable interest; insurable interest defined; insurer reliance on applicant's representations; insurable interest of charitable, etc. organization.

(1) Any individual of competent legal capacity may procure or effect an insurance contract upon his own life or body for the benefit of any person, but no person shall procure or cause to be procured any insurance contract upon the life or body of another individual unless the benefits under such contract are payable to the insured or his personal representatives or to a person having, at the time when such contract was made, an insurable interest in the insured.

(2) If the beneficiary, assignee or other payee under any contract made in violation of this section receives from the insurer any benefits from such contract accruing upon the death, disablement or injury of the insured, the insured or his executor or administrator may maintain an action to recover such benefits from the person so receiving them.

(3) For purposes of Sections 83-5-251 through 83-5-257, "insurable interest" means that a person has an insurable interest in the life, body and health of another individual as follows:

(a) The individual and the insured are related closely by blood or by law, a substantial interest engendered by love and affection;

(b) The person has a lawful and substantial economic interest in having the life, health or bodily safety of the insured continue, as distinguished from an interest which would arise only by, or would be enhanced in value by, the death, disablement or injury of the insured;

(c) A party to a contract or option for the purchase or sale of an interest in a business proprietorship, partnership or firm, or of shares of stock of a closed corporation or of an interest in such shares, has an insurable interest in the life, body and health of each individual party to such contract and for the purposes of such contract only, in addition to any insurable interest which may exist as to such individual;

(d) A person has a lawful interest in having the funeral expenses of the insured paid through insurance, provided the insured has knowledge of such insurance; and

(e) Any religious, educational, eleemosynary, charitable or benevolent institution or its agency may be named beneficiary in any policy of life insurance issued by any insurance company upon the life of any individual. A religious, educational, eleemosynary, charitable or benevolent institution or its agency designated as a beneficiary has an insurable interest for the full face of the policy and is entitled to collect the full face of the policy. Such institutions named as beneficiaries in policies issued before July 1, 1992, shall have an insurable interest for the full face of the policy and are entitled to collect the full face of the policy.

(4) An insurer shall be entitled to rely upon all reasonable statements, declarations and representations made by an applicant for insurance relative to the existence of an insurable interest; and no insurer shall incur legal liability except as set forth in the policy, by virtue of any untrue statements, declarations or representations so relied upon in good faith by the insurer.

(5) "Person" as used herein means artificial as well as natural persons, includes all public and private corporations as well as individuals, and includes a trust whose principal beneficiaries have an "insurable interest" as used herein. Any trust with policies issued after July 1, 1992, shall be deemed persons under this section.

HISTORY: Laws, 1992, ch. 522, § 1; Laws, 1993, ch. 400, § 1, eff from and after passage (approved March 15, 1993).

JUDICIAL DECISIONS

ANALYSIS

1. Proof required.
2. Insurable interest as in loco parentis.
3. Insurable interest and divorce.

1. Proof required.

Defendant failed to establish an "insurable interest" under Miss. Code Ann. § 83-5-251(3) of the life of an insured because he did not complete the process for guardianship under Miss. Code Ann. § 93-13-17 and he failed to establish a legal relationship or an economic interest in the continued life of the insured. First Colony Life Ins. Co. v. Sanford, 480 F. Supp. 2d 870, 2007 U.S. Dist. LEXIS 15503 (S.D. Miss. 2007), rev'd, 555 F.3d 177, 2009 U.S. App. LEXIS 341 (5th Cir. Miss. 2009).

2. Insurable interest as in loco parentis.

Even though a formal guardianship over an insured minor was not completed under Miss. Code Ann. § 93-13-17, factual disputes prevented summary judgment as to whether a claimant stood in loco parentis to the insured and as to whether other factors could have led to the claimant having an insurable interest under Miss. Code Ann. §§ 83-5-251 and 83-5-253 in the insured's life so as to allow the claimant to recover life insurance proceeds after the death of the insured. First Colony Life Ins. Co. v. Sanford, 555 F.3d 177, 2009 U.S. App. LEXIS 341 (5th Cir. Miss. 2009).

3. Insurable interest and divorce.

In this divorce case, it was not necessary for the wife to retain an insurable interest with the husband in order for the life insurance policy to remain valid, only to have an interest at the time when the contract was made, and even though the husband no longer wanted to name the wife as the beneficiary, he contracted to do so in the agreement. Voulters v. Voulters, 196 So. 3d 1019, 2015 Miss. App. LEXIS 654 (Miss. Ct. App. 2015), cert. denied, 202 So. 3d 612, 2016 Miss. LEXIS 310 (Miss. 2016).

RESEARCH REFERENCES

ALR.

Validity of assignment of life insurance policy to one who has no insurable interest in insured. 30 A.L.R.2d 1310.

Insurable interest of partner or partnership in life of partner. 70 A.L.R.2d 577.

Insurable interest of brother or sister in life of sibling. 60 A.L.R.3d 98.

Estoppel of, or waiver by, issuer of life insurance policy to assert defense of lack of insurable interest. 86 A.L.R.4th 828.

Am. Jur.
44 Am. Jur. 2d, Insurance §§ 978-1005.

CJS.
44 C.J.S., Insurance §§ 288-305.

§ 83-5-253. Consent of insured required in certain cases.

No life or health insurance contract upon an individual, except a contract of group life insurance or annuity or of group health insurance, or replacement contracts, shall be made or effectuated, unless at the time of the making of the contract the insured, applies therefor or has consented thereto in writing or has had the application acknowledged in writing by the insurance company, except that any person having an insurable interest in the life of a minor or any person upon whom a minor is dependent for support and maintenance may effectuate insurance upon the life of or pertaining to such minor.

HISTORY: Laws, 1992, ch. 522, § 2, eff from and after July 1, 1992.

JUDICIAL DECISIONS

1. In loco parentis creating an insurable interest.
Even though a formal guardianship over an insured minor was not completed under Miss. Code Ann. § 93-13-17, factual disputes prevented summary judgment as to whether a claimant stood in loco parentis to the insured and as to whether other factors could have led to the claimant having an insurable interest under Miss. Code Ann. §§ 83-5-251 and 83-5-253 in the insured's life so as to allow the claimant to recover life insurance proceeds after the death of the insured. First Colony Life Ins. Co. v. Sanford, 555 F.3d 177, 2009 U.S. App. LEXIS 341 (5th Cir. Miss. 2009).

§ 83-5-255. Enforcement by commissioner.

The Commissioner of Insurance is authorized to use any of the powers established under the insurance laws of the state to enforce Sections 83-5-251 through 83-5-257.

HISTORY: Laws, 1992, ch. 522, § 3, eff from and after July 1, 1992.

§ 83-5-257. Provisions cumulative of existing statutory and common law.

Sections 83-5-251 through 83-5-257 are cumulative of existing law in Mississippi, statutory and common law on the question of insurable interest.

HISTORY: Laws, 1992, ch. 522, § 4, eff from and after July 1, 1992.

ARTICLE 5.

FILING COPY OF ANNUAL STATEMENT WITH NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS; GENERATION OF REPORTS.

Sec.
83-5-301. Applicability of Sections 83-5-301 through 83-5-309.
83-5-303. Annual filings; hardship exemption; foreign insurers.
83-5-305. Civil liability of those dealing with information developed from filings.
83-5-307. Confidentiality.
83-5-309. Failure to file; revocation, suspension or refusal of certificate of authority.

§ 83-5-301. Applicability of Sections 83-5-301 through 83-5-309.

Sections 83-5-301 through 83-5-309 shall apply to all domestic, foreign and alien insurers authorized to transact business in this state.

HISTORY: Laws, 1994, ch. 646, § 1, eff from and after passage (approved April 8, 1994).

§ 83-5-303. Annual filings; hardship exemption; foreign insurers.

(1)(a) Each domestic, foreign and alien insurer authorized to transact insurance in this state shall annually on or before March 1 of each year, file with the National Association of Insurance Commissioners a copy of its annual statement convention blank, along with such additional filings as prescribed by the Commissioner of Insurance for the preceding year. The information filed with the National Association of Insurance Commissioners shall be in the same format and scope as that required by the Commissioner of Insurance and shall include the signed jurat page and the actuarial certification. Any amendments and addenda to the annual statement filing subsequently filed with the Commissioner of Insurance shall also be filed with the National Association of Insurance Commissioners.

(b) The Commissioner of Insurance may grant a hardship exemption to any domestic industrial life company transacting business in Mississippi only. No exemption shall be granted to any industrial life company transacting business across state lines.

(2) Foreign insurers that are domiciled in a state which has a law substantially similar to subsection (1) of this section shall be deemed in compliance with this section.

HISTORY: Laws, 1994, ch. 646, § 2, eff from and after passage (approved April 8, 1994).

§ 83-5-305. Civil liability of those dealing with information developed from filings.

In the absence of actual malice, members of the National Association of

Insurance Commissioners, their duly authorized committees, subcommittees and task forces, their delegates, National Association of Insurance Commissioners employees and all others charged with the responsibility of collecting, reviewing, analyzing and disseminating the information developed from the filing of the annual statement convention blanks shall be acting as agents of the Commissioner of Insurance under the authority of Sections 83-5-301 through 83-5-309 and, while performing such tasks, shall be subject to civil liability only to the same extent as the Commissioner of Insurance.

HISTORY: Laws, 1994, ch. 646, § 3, eff from and after passage (approved April 8, 1994).

§ 83-5-307. Confidentiality.

All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the Department of Insurance by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and may not be disclosed by the department.

HISTORY: Laws, 1994, ch. 646, § 4, eff from and after passage (approved April 8, 1994).

§ 83-5-309. Failure to file; revocation, suspension or refusal of certificate of authority.

The Commissioner of Insurance may suspend, revoke or refuse to renew the certificate of authority of any insurer failing to file its annual statement when due or within any extension of time which the commissioner, for good cause, may have granted.

HISTORY: Laws, 1994, ch. 646, § 5, eff from and after passage (approved April 8, 1994).

ARTICLE 6.

DISCLOSURE OF MATERIAL ACQUISITIONS, DISPOSITIONS OF ASSETS, AND REINSURANCE AGREEMENTS.

Sec.
83-5-351. Filing report; disclosure of material acquisitions and dispositions.
83-5-353. Reporting of material acquisitions or dispositions of assets.
83-5-355. No reporting of nonrenewals; cancellations; or revisions of ceded reinsurance agreements.
83-5-357. Promulgation of rules and regulations.

§ 83-5-351. Filing report; disclosure of material acquisitions and dispositions.

(1) Every insurer domiciled in this state shall file a report with the

Commissioner of Insurance disclosing material acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements unless the acquisitions and dispositions of assets or material nonrenewals, cancellations or revisions of ceded reinsurance agreements have been submitted to the commissioner for review, approval or information purposes under other provisions of the insurance laws, regulations or other requirements.

(2) The report required in subsection (1) of this section is due within fifteen (15) days after the end of the calendar month in which any of the transactions described in subsection (1) of this section occur.

(3) One (1) complete copy of the report, including any exhibits or other attachments, shall also be filed with the National Association of Insurance Commissioners.

(4) All reports obtained by or disclosed to the commissioner under Sections 83-5-351 through 83-5-357 shall be confidential and shall not be subject to subpoena and shall not be made public by the commissioner, the National Association of Insurance Commissioners or any other person, except to insurance departments of other states, without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer who would be affected notice and an opportunity to be heard, determines that the interest of policy holders, shareholders or the public will be served by publication, in which event the commissioner may publish all or any part in the manner the commissioner determines appropriate.

HISTORY: Laws, 1996, ch. 354, § 1, eff from and after July 1, 1996.

RESEARCH REFERENCES

Am. Jur.

43Am Jur 2d, Insurance §§ 519, 807.

44 Am. Jur. 2d, Insurance §§ 1131, 1140, 1559, 1889, 2063.

CJS.

44 C.J.S., Insurance §§ 479, 480.

Practice References.

Business Law Monographs (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

Liability of Corporate Officers and Directors, William E. Knepper, Dan A. Bailey, Stacy R. Lane, Katharine B. Bowman, Michael R. Goodstein, Darius N. Kandawalla (Matthew Bender).

§ 83-5-353. Reporting of material acquisitions or dispositions of assets.

(1) No acquisitions or dispositions of assets need be reported under Section 83-5-351 if the acquisitions or dispositions are not material. For purposes of Sections 83-5-351 through 83-5-357, a material acquisition or the aggregate of any series of related acquisitions during any thirty-day period or disposition or the aggregate of any series of related dispositions during any thirty-day period is one that is nonrecurring and not in the ordinary course of business and involves more than five percent (5%) of the reporting insurer's

total admitted assets as reported in its most recent financial statement filed with the commissioner.

(2)(a) Asset acquisitions subject to Sections 83-5-351 through 83-5-357 include every purchase, lease, exchange, merger, consolidation, succession or other acquisition other than the construction or development of real property by or for the reporting insurer or the acquisition of materials for such purpose.

(b) Asset dispositions subject to Sections 83-5-351 through 83-5-357 include every sale, lease, exchange, merger, consolidation, mortgage, hypothecation, assignment whether for the benefit of creditors or otherwise, abandonment, destruction or other disposition.

(3)(a) The following information is required to be disclosed in any report of a material acquisition or disposition of assets:

(i) Date of the transaction;

(ii) Manner of acquisition or disposition;

(iii) Description of the assets involved;

(iv) Nature and amount of the consideration given or received;

(v) Purpose of, or reason for, the transaction;

(vi) Manner by which the amount of consideration was determined;

(vii) Gain or loss recognized or realized as a result of the transaction; and

(viii) Name(s) of the person(s) from whom the assets were acquired or to whom they were disposed.

(4) Insurers are required to report material acquisitions and dispositions on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed business to a pool if the insurer has less than One Million Dollars ($1,000,000.00) total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus.

HISTORY: Laws, 1996, ch. 354, § 2, eff from and after July 1, 1996.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 802.

44 Am. Jur. 2d, Insurance §§ 1131, 1140, 1559, 1889, 2063.

CJS.

44 C.J.S., Insurance §§ 238, 239.

§ 83-5-355. No reporting of nonrenewals; cancellations; or revisions of ceded reinsurance agreements.

(1) No nonrenewals, cancellations or revisions of ceded reinsurance agree-

ments need be reported under Section 83-5-351 if the nonrenewals, cancellations or revisions are not material. For purposes of Sections 83-5-351 through 83-5-357, a material nonrenewal, cancellation or revision is one that affects:

(a) As respects property and casualty business, including accident and health business written by a property and casualty insurer:

(i) More than fifty percent (50%) of the insurer's total ceded written premium; or

(ii) More than fifty percent (50%) of the insurer's total ceded indemnity and loss adjustment reserves.

(b) As respects life, annuity, and accident and health business: more than fifty percent (50%) of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the insurer's most recent annual statement.

(c) As respects either property and casualty or life, annuity, and accident and health business, either of the following events shall constitute a material revision which must be reported:

(i) An authorized reinsurer representing more than ten percent (10%) of a total cession is replaced by one or more unauthorized reinsurers; or

(ii) Previously established collateral requirements have been reduced or waived as respects one or more unauthorized reinsurers representing collectively more than ten percent (10%) of a total cession.

(2) However, no filing shall be required if:

(a) As respects property and casualty business, including accident and health business written by a property and casualty insurer: the insurer's total ceded written premium represents, on an annualized basis, less than ten percent (10%) of its total written premium for direct and assumed business, or

(b) As respects life, annuity, and accident and health business: the total reserve credit taken from business ceded represents, on an annualized basis, less than ten percent (10%) of the statutory reserve requirement before any cession.

(3) The following information is required to be disclosed in any report of a material nonrenewal, cancellation or revision of ceded reinsurance agreements:

(a) Effective date of the nonrenewal, cancellation or revision;

(b) The description of the transaction with an identification of the initiator thereof;

(c) Purpose of, or reason for, the transaction; and

(d) If applicable, the identity of the replacement reinsurers.

(4) Insurers are required to report all material nonrenewals, cancellations or revisions of ceded reinsurance agreements on a nonconsolidated basis unless the insurer is part of a consolidated group of insurers which utilizes a pooling arrangement or one hundred percent (100%) reinsurance agreement that affects the solvency and integrity of the insurer's reserves and the insurer ceded substantially all of its direct and assumed business to the pool. An insurer is deemed to have ceded substantially all of its direct and assumed

business to a pool if the insurer has less than One Million Dollars ($1,000,000.00) total direct plus assumed written premiums during a calendar year that are not subject to a pooling arrangement and the net income of the business not subject to the pooling arrangement represents less than five percent (5%) of the insurer's capital and surplus.

HISTORY: Laws, 1996, ch. 354, § 3, eff from and after July 1, 1996.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 802.
44 Am. Jur. 2d, Insurance §§ 1131, 1140, 1559, 1889, 2063.

§ 83-5-357. Promulgation of rules and regulations.

The commissioner, after notices and hearings, may promulgate rules and regulations necessary to carry out the provisions of Sections 83-5-351 through 83-5-357.

HISTORY: Laws, 1996, ch. 354, § 4, eff from and after July 1, 1996.

ARTICLE 7.

RISK-BASED CAPITAL LEVEL REQUIREMENTS.

Sec.

83-5-401. Definitions.
83-5-403. Filing of RBC report; determination of insurer's RBC; maintenance of capital above prescribed RBC level; adjustment of report.
83-5-405. Procedure upon occurrence of company action level event.
83-5-407. Procedure upon occurrence of regulatory action level event.
83-5-409. Procedure upon occurrence of authorized control level event.
83-5-411. Procedure upon occurrence of mandatory control level event.
83-5-413. Hearings.
83-5-415. Confidentiality of reports and plans; sharing and using confidential information; publication, dissemination, etc., of information regarding capital level of insurer; rebuttal by insurer of materially false statement regarding capital level; use by commissioner of RBC instructions, reports and plans.
83-5-417. Relationship with other laws; promulgation of rules and regulations; exemption of domestic insurers and domestic health organization insurers.
83-5-419. Filing of RBC report or plan by foreign insurer.
83-5-421. Liability of commissioner, department, employees or agents.
83-5-423. Severability of provisions.
83-5-425. Effective date of notices.
83-5-427. Requirements for RBC reports for certain insurers for 1996; requirements for RBC reports for health organization insurers for 2013.

§ 83-5-401. Definitions.

As used in Sections 83-5-401 through 83-5-427, the following words and phrases shall have the meanings ascribed herein unless the context clearly indicates otherwise:

(a) "Adjusted RBC report" means a risk-based capital report which has been adjusted by the commissioner in accordance with Section 83-5-403(5).

(b) "Corrective order" means an order issued by the commissioner specifying corrective actions which the commissioner has determined are required.

(c) "Domestic insurer" means any insurance company domiciled in this state.

(d) "Foreign insurer" means any insurance company which is licensed to do business in this state under Section 83-21-1 et seq., but is not domiciled in this state.

(e) "NAIC" means the National Association of Insurance Commissioners.

(f) "Life and/or health insurer" means any insurance company licensed under Section 83-19-1 et seq., or a licensed property and casualty insurer writing only accident and health insurance.

(g) "Property and casualty insurer" means any insurance company licensed under Section 83-19-1 et seq., but shall not include monoline mortgage guaranty insurers, financial guaranty insurers and title insurers.

(h) "Negative trend" means, with respect to a life and/or health insurer, negative trend over a period of time, as determined in accordance with the "Trend Test Calculation" included in the Life RBC instructions.

(i) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the NAIC, as such RBC instructions may be amended by the NAIC from time to time in accordance with the procedures adopted by the NAIC.

(j) "RBC level" means an insurer's company action level RBC, regulatory action level RBC, authorized control level RBC, or mandatory control level RBC where:

(i) "Company action level RBC" means, with respect to any insurer, the product of 2.0 and its authorized control level RBC;

(ii) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC;

(iii) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(iv) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC.

(k) "RBC plan" means a comprehensive financial plan containing the elements specified in Section 83-5-405(2). If the commissioner rejects the RBC plan, and it is revised by the insurer, with or without the commissioner's recommendation, the plan shall be called the "revised RBC plan."

(*l*) "RBC report" means the report required in Section 83-5-403.

(m) "Total adjusted capital" means the sum of:

(i) An insurer's statutory capital and surplus as determined in accordance with the statutory accounting applicable to the annual financial statements required to be filed under Section 83-5-55; and

(ii) Such other items, if any, as the RBC instructions may provide.

(n) "Domestic health organization insurer" means a health organization insurer domiciled in this state.

(o) "Foreign health organization insurer" means a health organization insurer that is licensed to do business in this state under Section 83-21-1 et seq., but is not domiciled in this state.

(p) "Health organization insurer" means a health maintenance organization, limited health service organization, dental or vision plan, hospital, medical and dental indemnity or service corporation or other managed care organization that holds a certificate of authority under Section 83-41-305. This definition does not include an organization that is licensed as either a life and health insurer or property and casualty insurer and that is otherwise subject to either the life or property and casualty RBC requirements.

HISTORY: Laws, 1996, ch. 478, § 1; Laws, 2010, ch. 340, § 1; Laws, 2013, ch. 416, § 3, eff from and after July 1, 2013.

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

RESEARCH REFERENCES

Practice References.

Business Law Monographs (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

Liability of Corporate Officers and Directors, William E. Knepper, Dan A. Bailey, Stacy R. Lane, Katharine B. Bowman, Michael R. Goodstein, Darius N. Kandawalla (Matthew Bender).

§ 83-5-403. Filing of RBC report; determination of insurer's RBC; maintenance of capital above prescribed RBC level; adjustment of report.

(1) Every domestic insurer shall, on or before each March 1, the filing date, prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing such information as is required by the RBC instructions. In addition, every domestic insurer shall file its RBC report:

(a) With the NAIC in accordance with the RBC instructions; and

(b) With the insurance commissioner in any state in which the insurer is authorized to do business, if the insurance commissioner has notified the insurer of its request in writing, in which case the insurer shall file its RBC report not later than the later of:

(i) Fifteen (15) days from the receipt of notice to file its RBC report with that state; or

(ii) The filing date.

(2) A life and health insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account, and may adjust for the covariance between, the following factors determined in each case by applying the factors in the manner set forth in the RBC instructions.

(a) The risk with respect to the insurer's assets;

(b) The risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) The interest rate risk with respect to the insurer's business; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(3) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account, and may adjust for the covariance between, determined in each case by applying the factors in the manner set forth in the RBC instructions:

(a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(4) A health organization insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account (and may adjust for the covariance between) determined in each case by applying the factors in the manner set forth in the RBC instructions:

(a) Asset risk;

(b) Credit risk;

(c) Underwriting risk; and

(d) All other business risks and such other relevant risks as are set forth in the RBC instructions.

(5) An excess of capital over the amount produced by the risk-based capital requirements contained in Sections 83-5-401 through 83-5-427 and the formulas, schedules and instructions referenced in Sections 83-5-401 through 83-5-427, is desirable in the business of insurance. Accordingly, insurers should seek to maintain capital above the RBC levels required by Sections 83-5-401 through 83-5-427. Additional capital is used and useful in the insurance business and helps to secure an insurer against various risks inherent in, or affecting, the business of insurance and not accounted for or only partially measured by the risk-based capital requirements contained in Sections 83-5-401 through 83-5-427.

(6) If a domestic insurer files a RBC report which in the judgment of the commissioner is inaccurate, then the commissioner shall adjust the RBC

report to correct the inaccuracy and shall notify the insurer of the adjustment. The notice shall contain a statement of the reason for the adjustment. A RBC report as so adjusted is referred to as an "adjusted RBC report."

HISTORY: Laws, 1996, ch. 478, § 2; Laws, 2010, ch. 340, § 2; Laws, 2013, ch. 416, § 4, eff from and after July 1, 2013.

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:
"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

§ 83-5-405. Procedure upon occurrence of company action level event.

(1) "Company action level event" means any of the following events:

(a) The filing of a RBC report by an insurer which indicates that:

(i) The insurer's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(ii) If a life and/or health insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and has a negative trend; or

(iii) If a property and casualty insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculation included in the property and casualty RBC instructions;

(iv) If a health organization insurer, the insurer has total adjusted capital which is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0 and triggers the trend test determined in accordance with the trend test calculations included in the health RBC instructions;

(b) The notification by the commissioner to the insurer of an adjusted RBC report that indicates an event in paragraph (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under Section 83-5-413; or

(c) If, under Section 83-5-413, an insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(2) In the event of a company action level event, the insurer shall prepare and submit to the commissioner a RBC plan which shall:

(a) Identify the conditions which contribute to the company action level event;

(b) Contain proposals of corrective actions which the insurer intends to take and would be expected to result in the elimination of the company action level event;

(c) Provide projections of the insurer's financial results in the current year and at least the four (4) succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of statutory operating income, net income, capital and surplus. The projections for both new and renewal business might include separate projections for each major line of business and separately identify each significant income, expense and benefit component;

(d) Identify the key assumptions impacting the insurer's projections and the sensitivity of the projections to the assumptions; and

(e) Identify the quality of, and problems associated with, the insurer's business, including, but not limited to, its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(3) The RBC plan shall be submitted:

(a) Within forty-five (45) days of the company action level event; or

(b) If the insurer challenges an adjusted RBC report under Section 83-5-413, within forty-five (45) days after notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) Within sixty (60) days after the submission by an insurer of a RBC plan to the commissioner, the commissioner shall notify the insurer whether the RBC plan shall be implemented or is, in the judgment of the commissioner, unsatisfactory. If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer shall set forth the reasons for the determination, and may set forth proposed revisions which will render the RBC plan satisfactory, in the judgment of the commissioner. Upon notification from the commissioner, the insurer shall prepare a revised RBC plan, which may incorporate by reference any revisions proposed by the commissioner, and shall submit the revised RBC plan to the commissioner:

(a) Within forty-five (45) days after the notification from the commissioner; or

(b) If the insurer challenges the notification from the commissioner under Section 83-5-413, within forty-five (45) days after a notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(5) In the event of a notification by the commissioner to an insurer that the insurer's RBC plan or revised RBC plan is unsatisfactory, the commissioner may at the commissioner's discretion, subject to the insurer's right to a hearing under Section 83-5-413, specify in the notification that the notification constitutes a regulatory action level event.

(6) Every domestic insurer that files a RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer is authorized to do business if:

(a) Such state has a RBC provision substantially similar to Section 83-5-415(1); and

(b) The insurance commissioner of that state has notified the insurer of its request for the filing in writing, in which case the insurer shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) Fifteen (15) days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with the state; or

(ii) The date on which the RBC plan or revised RBC plan is filed under Section 83-5-405(3) and (4).

HISTORY: Laws, 1996, ch. 478, § 3; Laws, 2010, ch. 340, § 3; Laws, 2013, ch. 416, § 5; Laws, 2016, ch. 304, § 1, eff from and after July 1, 2016.

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Cross References — Reporting requirements for 1996, see § 83-5-427.

§ 83-5-407. Procedure upon occurrence of regulatory action level event.

(1) "Regulatory action level event" means, with respect to any insurer, any of the following events:

(a) The filing of a RBC report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) The notification by the commissioner to an insurer of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, provided the insurer does not challenge the adjusted RBC report under Section 83-5-413;

(c) If under Section 83-5-413, the insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge;

(d) The failure of the insurer to file a RBC report by the filing date, unless the insurer has provided an explanation for such failure which is satisfactory to the commissioner and has cured the failure within ten (10) days after the filing date;

(e) The failure of the insurer to submit a RBC plan to the commissioner within the time period set forth in Section 83-5-405(3);

(f) Notification by the commissioner to the insurer that;

(i) The RBC plan or revised RBC plan submitted by the insurer is, in the judgment of the commissioner, unsatisfactory; and

(ii) Such notification constitutes a regulatory action level event with respect to the insurer, provided the insurer has not challenged the determination under Section 83-5-413;

(g) If, under Section 83-5-413, the insurer challenges a determination by the commissioner under paragraph (f) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected such challenge;

(h) Notification by the commissioner to the insurer that the insurer has failed to adhere to its RBC plan or revised RBC plan, but only if such failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event in accordance with its RBC plan or revised RBC plan and the commissioner has so stated in the notification, provided the insurer has not challenged the determination under Section 83-5-413; or

(i) If, under Section 83-5-413, the insurer challenges a determination by the commissioner under paragraph (h) of this subsection, the notification by the commissioner to the insurer that the commissioner has, after a hearing, rejected the challenge.

(2) In the event of a regulatory action level event the commissioner shall:

(a) Require the insurer to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) Perform such examination or analysis as the commissioner deems necessary of the assets, liabilities and operations of the insurer including a review of its RBC plan or revised RBC plan; and

(c) Subsequent to the examination or analysis, issue an order specifying such corrective actions as the commissioner shall determine are required.

(3) In determining corrective actions, the commissioner may take into account such factors as are deemed relevant with respect to the insurer based upon the commissioner's examination or analysis of the assets, liabilities and operations of the insurer, including, but not limited to, the results of any sensitivity tests undertaken in accordance with the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) Within forty-five (45) days after the occurrence of the regulatory action level event;

(b) If the insurer challenges an adjusted RBC report under Section 83-5-413 and the challenge is not frivolous in the judgment of the commissioner, within forty-five (45) days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge; or

(c) If the insurer challenges a revised RBC plan under Section 83-5-413 and the challenge is not frivolous in the judgment of the commissioner, within forty-five (45) days after the notification to the insurer that the commissioner has, after a hearing, rejected the insurer's challenge.

(4) The commissioner may retain actuaries and investment experts and other consultants as may be necessary in the judgment of the commissioner to review the insurer's RBC plan or revised RBC plan, examine or analyze the assets, liabilities and operations of the insurer and formulate the corrective order with respect to the insurer. The fees, costs and expenses relating to consultants shall be borne by the affected insurer or such other party as directed by the commissioner.

HISTORY: Laws, 1996, ch. 478, § 4, eff from and after July 1, 1996.

Cross References — Reporting requirements for 1996, see § 83-5-427.

§ 83-5-409. Procedure upon occurrence of authorized control level event.

(1) "Authorized control level event" means any of the following events:

(a) The filing of a RBC report by the insurer which indicates that the insurer's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) The notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, if the insurer does not challenge the adjusted RBC report under Section 83-5-413;

(c) Under Section 83-5-413, the insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge;

(d) The failure of the insurer to respond, in a manner satisfactory to the commissioner, to a corrective order if the insurer has not challenged the corrective order under Section 83-5-413; or

(e) If the insurer has challenged a corrective order under Section 83-5-413 and the commissioner has, after a hearing, rejected the challenge or modified the corrective order, the failure of the insurer to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2) In the event of an authorized control level event with respect to an insurer, the commissioner shall:

(a) Take such actions as are required under Section 83-5-407 regarding an insurer with respect to which a regulatory action level event has occurred; or

(b) If the commissioner determines it to be in the best interests of the policyholders and creditors of the insurer and of the public, take such actions as are necessary to cause the insurer to be placed under regulatory control under Section 83-24-1 et seq. In the event the commissioner takes such actions, the authorized control level event shall be deemed sufficient grounds for the commissioner to take action under Section 83-24-1 et seq., and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Section 83-24-1 et seq. In the event the commissioner takes actions under this paragraph under an adjusted RBC report, the insurer shall be entitled to such protections as are afforded to insurers under the provisions of Section 83-24-1 et seq., pertaining to summary proceedings.

HISTORY: Laws, 1996, ch. 478, § 5, eff from and after July 1, 1996.

Cross References — Procedure upon occurrence of regulatory action level event, see § 83-5-407.

Reporting requirements for 1996, see § 83-5-427.

§ 83-5-411. Procedure upon occurrence of mandatory control level event.

(1) "Mandatory control level event" means any of the following events:

(a) The filing of a RBC report which indicates that the insurer's total adjusted capital is less than its mandatory control level RBC.

(b) Notification by the commissioner to the insurer of an adjusted RBC report that indicates the event in paragraph (a) of this subsection, if the insurer does not challenge the adjusted RBC report under Section 83-5-413; or

(c) If, under Section 83-5-413, the insurer challenges an adjusted RBC report that indicates the event in paragraph (a) of this subsection, notification by the commissioner to the insurer that the commissioner, after a hearing, has rejected the insurer's challenge.

(2) In the event of a mandatory control level event:

(a) With respect to a life insurer, the commissioner shall take such actions as are necessary to place the insurer under regulatory control under Section 83-24-1 et seq. In that event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under Section 83-24-1 et seq., and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Section 83-24-1 et seq. If the commissioner takes actions under an adjusted RBC report, the insurer shall be entitled to the protections of law pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety (90) days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

(b) With respect to a property and casualty insurer, the commissioner shall take such actions as are necessary to place the insurer under regulatory control under Section 83-24-1 et seq., or, in the case of an insurer which is writing no business and which is running-off its existing business, may allow the insurer to continue its run-off under the supervision of the commissioner. In either event, the mandatory control level event shall be deemed sufficient grounds for the commissioner to take action under Section 83-24-1 et seq., and the commissioner shall have the rights, powers and duties with respect to the insurer as are set forth in Section 83-24-1 et seq. If the commissioner takes actions under an adjusted RBC report, the insurer shall be entitled to the protections of law pertaining to summary proceedings. Notwithstanding any of the foregoing, the commissioner may forego action for up to ninety (90) days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the ninety-day period.

HISTORY: Laws, 1996, ch. 478, § 6, eff from and after July 1, 1996.

Cross References — Reporting requirements for 1996, see § 83-5-427.

§ 83-5-413. Hearings.

In order to maintain the integrity of proceedings and prevent undue advantage to a competitor by disclosure of proprietary information, the insurer shall have the right to a confidential departmental hearing, on a record, at which the insurer may challenge any determination or action by the commissioner after notification by the commissioner as provided in this section. The insurer shall notify the commissioner of its request for a hearing within five (5) days after the notification by the commissioner under paragraph (a), (b), (c) or (d) of this section. Upon receipt of the insurer's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than ten (10) nor more than thirty (30) days after the date of the insurer's request.

The notifications are as follows:

(a) Notification to an insurer by the commissioner of an adjusted RBC report; or

(b) Notification to an insurer by the commissioner that:

(i) The insurer's RBC plan or revised RBC plan is unsatisfactory; and

(ii) Such notification constitutes a regulatory action level event with respect to such insurer; or

(c) Notification to any insurer by the commissioner that the insurer has failed to adhere to its RBC plan or revised RBC plan and that such failure has a substantial adverse effect on the ability of the insurer to eliminate the company action level event with respect to the insurer in accordance with its RBC plan or revised RBC plan; or

(d) Notification to an insurer by the commissioner of a corrective order with respect to the insurer.

HISTORY: Laws, 1996, ch. 478, § 7, eff from and after July 1, 1996.

Cross References — Procedure upon occurrence of company action level event, see § 83-5-405.
Procedure upon occurrence of regulatory action level event, see § 83-5-407.
Procedure upon occurrence of authorized control level event, see § 83-5-409.
Procedure upon occurrence of mandatory control level event, see § 83-5-411.
Effective date of notices, see § 83-5-425.

§ 83-5-415. Confidentiality of reports and plans; sharing and using confidential information; publication, dissemination, etc., of information regarding capital level of insurer; rebuttal by insurer of materially false statement regarding capital level; use by commissioner of RBC instructions, reports and plans.

(1) All RBC reports, to the extent the information therein is not required to be set forth in a publicly available annual statement schedule, and RBC plans, including the results or report of any examination or analysis of an insurer performed pursuant hereto and any corrective order issued by the commissioner, as a result of examination or analysis, with respect to any

domestic insurer or foreign insurer, which are filed with the commissioner constitute information that might be damaging to the insurer if made available to its competitors and shall be kept confidential by the commissioner. This information shall not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner under Sections 83-5-401 through 83-5-427 or any other provision of the insurance laws of this state. All RBC reports and RBC plans filed with the commissioner shall be privileged and exempt from the provisions of the Mississippi Public Records Act in accordance with Section 25-61-11.

(2) In order to assist in the performance of the commissioner's duties, the commissioner:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (1) of this section, with other state, federal and international regulatory agencies, with the NAIC and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(b) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(c) May enter into agreements governing sharing and using information consistent with this subsection (2).

(3) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (2) of this section.

(4) The comparison of an insurer's total adjusted capital to any of its RBC levels is a regulatory tool which may indicate the need for corrective action with respect to the insurer and is not intended as a means to rank insurers generally. Except as otherwise required under the provisions of Sections 83-5-401 through 83-5-427, the making, publishing, disseminating, circulating or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated or placed before the public, in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station, or in any other way, an advertisement, announcement or statement containing an assertion, representation or statement with regard to the RBC levels of any insurer, or of any component derived in the calculation, by any insurer, agent, broker or other person engaged in any manner in the insurance business is prohibited. If any materially false statement with respect to the comparison

regarding an insurer's total adjusted capital to its RBC levels, or any of them, or an inappropriate comparison of any other amount to the insurers' RBC levels is published in any written publication and the insurer is able to demonstrate to the commissioner with substantial proof the falsity of such statement, or the inappropriateness, as the case may be, then the insurer may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement.

(5) RBC instructions, RBC reports, adjusted RBC reports, RBC plans and revised RBC plans are intended solely for use by the commissioner in monitoring the solvency of insurers and the need for possible corrective action with respect to insurers and shall not be used by the commissioner for ratemaking nor considered or introduced as evidence in any rate proceeding nor used by the commissioner to calculate or derive any elements of an appropriate premium level or rate of return for any line of insurance which an insurer or an affiliate is authorized to write.

HISTORY: Laws, 1996, ch. 478, § 8; Laws, 2010, ch. 340, § 4, eff from and after July 1, 2010.

Cross References — Mississippi Public Records Act, see § 25-61-1 et seq.
Procedure upon occurrence of company action level event, see § 83-5-405.

§ 83-5-417. Relationship with other laws; promulgation of rules and regulations; exemption of domestic insurers and domestic health organization insurers.

(1) The provisions of Sections 83-5-401 through 83-5-427 are supplemental to any other provisions of the laws of this state and shall not preclude or limit any other powers or duties of the commissioner under such laws.

(2) The commissioner may promulgate rules and regulations necessary for the implementation of Sections 83-5-401 through 83-5-427.

(3) The commissioner may exempt from the application of Sections 83-5-401 through 83-5-427 any domestic insurer, other than a domestic health organization insurer, that:

(a) Writes direct business only in this state;

(b) Writes direct annual premiums of Two Million Dollars ($2,000,000.00) or less; and

(c) Assumes no reinsurance in excess of five percent (5%) of direct premium written.

(4) The commissioner may exempt from the application of Sections 83-5-401 through 83-5-427 a domestic health organization insurer that:

(a) Writes direct business only in this state;

(b) Assumes no reinsurance in excess of five percent (5%) of direct premium written; and

(c) Writes direct annual premiums for comprehensive medical business of Two Million Dollars ($2,000,000.00) or less, or is a limited health service organization that covers less than two thousand (2,000) lives.

HISTORY: Laws, 1996, ch. 478, § 9; Laws, 2013, ch. 416, § 6, eff from and after July 1, 2013.

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:
"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

§ 83-5-419. Filing of RBC report or plan by foreign insurer.

(1) Any foreign insurer, upon the written request of the commissioner, shall submit to the commissioner a RBC report as of the end of the calendar year just ended the later of:

(a) The date a RBC report would be required to be filed by a domestic insurer under Sections 83-5-401 through 83-5-427; or

(b) Fifteen (15) days after the request is received by the foreign insurer.

Any foreign insurer shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(2) In the event of a company action level event, regulatory action level event or authorized control level event with respect to any foreign insurer as determined under the RBC statute applicable in the state of domicile of the insurer, or, if no RBC statute is in force in that state, under the provisions of Sections 83-5-401 through 83-5-427, if the insurance commissioner of the state of domicile of the foreign insurer fails to require the foreign insurer to file a RBC plan in the manner specified under that state's RBC statute, or if no RBC statute is in force in that state, under Section 83-5-405, the commissioner may require the foreign insurer to file a RBC plan with the commissioner. In such event, the failure of the foreign insurer to file a RBC plan with the commissioner shall be grounds to order the insurer to cease writing new insurance business in this state.

(3) In the event of a mandatory control level event with respect to any foreign insurer, if no domiciliary receiver has been appointed with respect to the foreign insurer under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer, the commissioner may make application to the court as permitted under Section 83-24-1 et seq., with respect to the liquidation of property of foreign insurers found in this state, and the occurrence of the mandatory control level event shall be considered adequate grounds for the application.

HISTORY: Laws, 1996, ch. 478, § 10, eff from and after July 1, 1996.

§ 83-5-421. Liability of commissioner, department, employees or agents.

There shall be no liability on the part of, and no cause of action shall arise against, the commissioner or the insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under Sections 83-5-401 through 83-5-427.

HISTORY: Laws, 1996, ch. 478, § 11, eff from and after July 1, 1996.

§ 83-5-423. Severability of provisions.

If any provision of Sections 83-5-401 through 83-5-427, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of Sections 83-5-401 through 83-5-427 which can be given effect without the invalid provision or application, and to that end the provisions of Sections 83-5-401 through 83-5-427 are severable.

HISTORY: Laws, 1996, ch. 478, § 12, eff from and after July 1, 1996.

§ 83-5-425. Effective date of notices.

All notices by the commissioner to an insurer which may result in regulatory action hereunder shall be effective upon dispatch if transmitted by registered or certified mail, or in the case of any other transmissions shall be effective upon the insurer's receipt of such notice.

HISTORY: Laws, 1996, ch. 478, § 13, eff from and after July 1, 1996.

§ 83-5-427. Requirements for RBC reports for certain insurers for 1996; requirements for RBC reports for health organization insurers for 2013.

(1) For RBC reports required to be filed by life insurers with respect to 1996, the following requirements shall apply in lieu of the provisions of Sections 83-5-405, 83-5-407, 83-5-409, and 83-5-411.

(a) In the event of a company action level event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder.

(b) In the event of a regulatory action level event under Section 83-5-407(1)(a), (b) or (c), the commissioner shall take the actions required under Section 83-5-405.

(c) In the event of a regulatory action level event under Section 83-5-407(1)(d), (e), (f), (g), (h) or (i), or an authorized control level event, the commissioner shall take the actions required under Section 83-5-407 with respect to the insurer.

(d) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under Section 83-5-409 with respect to the insurer.

(2) For RBC reports required to be filed by property and casualty insurers with respect to 1996, the following requirements shall apply in lieu of the provisions of Sections 83-5-405, 83-5-407, 83-5-409, and 83-5-411:

(a) In the event of a company action level event with respect to a domestic insurer, the commissioner shall take no regulatory action hereunder.

(b) In the event of a regulatory action level event under Section

83-5-407(1)(a), (b) or (c), the commissioner shall take the actions required under Section 83-5-405.

(c) In the event of a regulatory action level event under Section 83-5-407(1)(d), (e), (f), (g), (h) or (i), or an authorized control level event, the commissioner shall take the actions required under Section 83-5-407 with respect to the insurer.

(d) In the event of a mandatory control level event with respect to an insurer, the commissioner shall take the actions required under Section 83-5-409 with respect to the insurer.

(3) For RBC reports required to be filed by health organization insurers with respect to 2013, the following requirements shall apply in lieu of the provisions of Sections 83-5-405, 83-5-407, 83-5-409 and 83-5-411:

(a) In the event of a company action level event with respect to a domestic health organization insurer, the commissioner shall take no regulatory action hereunder;

(b) In the event of a regulatory action level event under Section 83-5-407(1)(a), (b) or (c), the commissioner shall take the actions required under Section 83-5-405;

(c) In the event of a regulatory action level event under Section 83-5-407(1)(d), (e), (f), (g), (h) or (i), or an authorized control level event, the commissioner shall take the actions required under Section 83-5-407 with respect to the health organization insurer; and

(d) In the event of a mandatory control level event with respect to a health organization insurer, the commissioner shall take the actions required under Section 83-5-409 with respect to the health organization insurer.

HISTORY: Laws, 1996, ch. 478, § 14; Laws, 2013, ch. 416, § 7, eff from and after July 1, 2013.

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

ARTICLE 8.

PROPERTY AND CASUALTY ACTUARIAL OPINION ACT.

Sec.
83-5-501. Title.
83-5-503. Actuarial opinion of reserves and supporting documentation.
83-5-505. Confidentiality.
83-5-507. Repealed.

§ 83-5-501. Title.

Sections 83-5-501 through 83-5-505 shall be known as the "Property and Casualty Actuarial Opinion Act."

HISTORY: Laws, 2009, ch. 441, § 1; reenacted without change, Laws, 2012, ch. 306, § 1, eff from and after July 1, 2012.

RESEARCH REFERENCES

Practice References.

Business Law Monographs, Volume IN2--Casualty and Liability Insurance (Matthew Bender elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

Liability of Corporate Officers and Directors, William E. Knepper, Dan A. Bailey, Stacy R. Lane, Katharine B. Bowman, Michael R. Goodstein, Darius N. Kandawalla (Matthew Bender).

§ 83-5-503. Actuarial opinion of reserves and supporting documentation.

(1) **Statement of Actuarial Opinion.** Every property and casualty insurance company doing business in this state, unless otherwise exempted by the domiciliary commissioner, shall annually submit the opinion of an appointed actuary entitled "Statement of Actuarial Opinion." This opinion shall be filed in accordance with the appropriate National Association of Insurance Commissioners (NAIC) Property and Casualty Annual Statement Instructions.

(2)(a) **Actuarial Opinion Summary.** Every property and casualty insurance company domiciled in this state that is required to submit a Statement of Actuarial Opinion shall annually submit an Actuarial Opinion Summary, written by the company's appointed actuary. This Actuarial Opinion Summary shall be filed in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and shall be considered as a document supporting the actuarial opinion required in subsection (1).

(b) A company licensed but not domiciled in this state shall provide the Actuarial Opinion Summary upon request.

(3)(a) **Actuarial report and workpapers.** An actuarial report and underlying workpapers as required by the appropriate NAIC Property and Casualty Annual Statement Instructions shall be prepared to support each actuarial opinion.

(b) If the insurance company fails to provide a supporting actuarial report and/or workpapers at the request of the commissioner or the commissioner determines that the supporting actuarial report or workpapers provided by the insurance company is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting actuarial report or workpapers.

(4) The appointed actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion, except in cases of fraud or willful misconduct on the part of the appointed actuary.

HISTORY: Laws, 2009, ch. 441, § 2; reenacted without change, Laws, 2012, ch. 306, § 2, eff from and after July 1, 2012.

RESEARCH REFERENCES

Practice References.

Cyber Risks, Social Media and Insurance: A Guide to Risk Assessment and Management, Carrie E. Cope, Esq., Dirk E. Ehlers, Keith W. Mandell.

§ 83-5-505. Confidentiality.

(1) The Statement of Actuarial Opinion shall be provided with the annual statement in accordance with the appropriate NAIC Property and Casualty Annual Statement Instructions and shall be treated as a public document.

(2)(a) Documents, materials or other information in the possession or control of the Department of Insurance that are considered an actuarial report, workpapers or Actuarial Opinion Summary provided in support of the opinion, and any other material provided by the company to the commissioner in connection with the actuarial report, workpapers or Actuarial Opinion Summary, shall be confidential by law and privileged, shall not be subject to the Mississippi Public Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

(b) This section shall not be construed to limit the commissioner's authority to release the documents to the Actuarial Board for Counseling and Discipline (ABCD) so long as the material is required for the purpose of professional disciplinary proceedings and that the ABCD establishes procedures satisfactory to the commissioner for preserving the confidentiality of the documents, nor shall this section be construed to limit the commissioner's authority to use the documents, materials or other information in furtherance of any regulatory or legal action brought as part of the commissioner's official duties.

(3) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (2).

(4) In order to assist in the performance of the commissioner's duties, the commissioner:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (2) with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information and has the legal authority to maintain confidentiality;

(b) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners and its affiliates and subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(c) May enter into agreements governing sharing and use of information consistent with subsections (2), (3) and (4).

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (4).

HISTORY: Laws, 2009, ch. 441, § 3; reenacted without change, Laws, 2012, ch. 306, § 3, eff from and after July 1, 2012.

Cross References — Mississippi Public Records Act, see § 25-61-1 et seq.

§ 83-5-507. Repealed.

Repealed by Laws of 2012, ch. 306, § 4, effective July 1, 2012.

§ 83-5-507. [Laws, 2009, ch. 441, § 4, eff from and after Jan. 1, 2010.]

Editor's Notes — Former § 83-5-507 would have repealed §§ 83-5-501 through 83-5-507, effective July 1, 2012.

ARTICLE 9.

PROVIDER-SPONSORED HEALTH PLANS.

Sec.	
83-5-601.	Legislative findings and intent.
83-5-603.	Provider-Sponsored Health Plan defined.
83-5-605.	Providers of provider-sponsored health plans must meet certain requirements before offering or providing services.
83-5-607.	Requirements of provider-sponsored health plans.

§ 83-5-601. Legislative findings and intent.

(1) In order to encourage and facilitate collaboration between Mississippi Medicaid providers and managed care entities contracting on a capitated basis with the Division of Medicaid pursuant to Section 43-13-117(H), to align incentives in support of integrated and coordinated health care delivery, and to encourage the development of appropriate population or community health strategies to better serve Medicaid beneficiaries and the state's health care delivery system as a whole, the Legislature hereby authorizes and encourages the creation of provider-sponsored health plans as defined in Section 83-5-603.

(2) Whereas, for the reasons stated in subsection (1), the authorization and development of provider-sponsored health plans as defined in Section

83-5-603 are vital to the continued delivery and improvement of health care in this state and otherwise in the best interests of the state and its citizens, and notwithstanding any other provision of law to the contrary, a provider-sponsored health plan, and its owners, officers, directors, committee members, agents, representatives, and employees, when performing the functions authorized by this article, in carrying out the terms of any contract with or program of the Division of Medicaid, and in collaborating and communicating with hospitals, physicians, and other providers for such purposes, shall be considered to be acting pursuant to clearly expressed state policy as established in this article under the supervision of the State of Mississippi and shall be immune from liability under state or federal antitrust laws while so acting.

HISTORY: Laws, 2015, ch. 446, § 1, eff from and after July 1, 2015.

Editor's Notes — Laws of 2015, ch. 446, § 5 provides:

"SECTION 5. This act shall be codified as a separate article within Chapter 5, Title 83, Mississippi Code of 1972."

§ 83-5-603. Provider-Sponsored Health Plan defined.

As used in this article, "Provider-Sponsored Health Plan" means a Mississippi not-for-profit corporation formed for the purposes of operating a not-for-profit health plan or managed care entity, with its principal place of business within the State of Mississippi, and which is owned and governed exclusively by (a) not-for-profit Mississippi hospital or physician industry or trade association in which the majority of the hospitals or physicians within the state are members, or (b) a combination of (i) not-for-profit Mississippi hospital or physician industry or trade associations that represent a majority of the hospitals or physicians within the state, and (ii) licensed Mississippi hospitals or physicians who participate in the Mississippi Medicaid Program. At least one (1) purpose of the provider-sponsored health plan shall be to contract with the Division of Medicaid to provide managed care services on a capitated basis pursuant to Section 43-13-117(H). To qualify as a provider-sponsored health plan under this section, the entity must further meet the requirements of Section 83-5-607.

HISTORY: Laws, 2015, ch. 446, § 2, eff from and after July 1, 2015.

§ 83-5-605. Providers of provider-sponsored health plans must meet certain requirements before offering or providing services.

Before offering or providing services to persons residing in this state, the Department of Insurance shall certify that any entity applying to operate in this state as a provider-sponsored health plan meets the definition provided in Section 83-5-603 and has been licensed as either a health maintenance organization pursuant to Section 83-41-1 et seq., or as an insurance company pursuant to Section 83-19-1 et seq. Provider-sponsored health plans shall comply with the requirement for health maintenance organizations as established by the department pursuant to Section 83-41-1 et seq., or an insurance company pursuant to Section 83-19-1 et seq.

HISTORY: Laws, 2015, ch. 446, § 3, eff from and after July 1, 2015.

Editor's Notes — Sections 83-41-1 through 83-41-19, included in sections referenced in 83-41-1 et seq., provided for the organization and regulation of hospital and medical service associations by the Commissioner of Insurance and were repealed by Section 1 of Chapter 307, Laws of 1997, effective from and after July 1, 1997. Sections 83-41-101 through 83-41-131, also included in the referenced Section 83-41-1 et seq., provided for the organization and regulation of nonprofit hospital, medical and surgical service corporations by the Commissioner of Insurance, and were repealed by Section 2 of Chapter 307, Laws of 1997, effective from and after July 1, 1997.

§ 83-5-607. Requirements of provider-sponsored health plans.

Provider-sponsored health plans shall:

(a) Demonstrate ownership or substantial representation in governance and operations by licensed Mississippi hospitals and physicians that participate in the Mississippi Medicaid Program. Notwithstanding any other provision of law to the contrary, for the purpose of meeting this requirement, hospitals owned by the state and hospitals owned by local governmental entities are authorized to provide funds for the establishment and operation of provider-sponsored health plans, provided the hospital governing body first determines that such participation is in the best interest of the hospital and the communities it serves;

(b) Satisfy the minimum financial and reserve requirements to be established by the Department of Insurance;

(c) Meet all contractual requirements for contracting with the Division of Medicaid to provide managed care or coordinated care services to Medicaid recipients pursuant to Section 43-13-117(H). Compliance with this requirement shall be determined and supervised by the Division of Medicaid. Nothing in this article shall be construed as giving the Department of Insurance responsibility or authority for the operation of the State Medicaid Program; and

(d) Such other requirements as may be established by valid regulation of the Department of Insurance.

HISTORY: Laws, 2015, ch. 446, § 4, eff from and after July 1, 2015.

ARTICLE 10.

CORPORATE GOVERNANCE ANNUAL DISCLOSURES

Sec.

83-5-701. Purpose; relation to other laws; applicability.
83-5-703. Definitions.
83-5-705. Disclosure requirement; permissible levels of reporting.
83-5-707. Promulgation of rules, regulations and orders.

Sec.
83-5-709. Contents of corporate governance annual disclosure.
83-5-711. Confidentiality.
83-5-713. NAIC and third-party consultants.
83-5-715. Penalties for failure to file.
83-5-717. Severability.

§ 83-5-701. Purpose; relation to other laws; applicability.

(1) The purpose of this article is to:

(a) Provide the Commissioner of Insurance a summary of an insurer or insurance group's corporate governance structure, policies and practices to permit the commissioner to gain and maintain an understanding of the insurer's corporate governance framework.

(b) Outline the requirements for completing a corporate governance annual disclosure with the Commissioner of Insurance.

(c) Provide for the confidential treatment of the corporate governance annual disclosure and related information that will contain confidential and sensitive information related to an insurer or insurance group's internal operations and proprietary and trade secret information which, if made public, could potentially cause the insurer or insurance group competitive harm or disadvantage.

(2) Nothing in this article shall be construed to prescribe or impose corporate governance standards and internal procedures beyond that which is required under applicable state corporate law. Notwithstanding the foregoing, nothing in this article shall be construed to limit the commissioner's authority, or the rights or obligations of third parties, under Section 83-5-201.

(3) The requirements of this article shall apply to all insurers domiciled in this state.

HISTORY: Laws, 2019, ch. 343, § 1, eff from and after January 1, 2020.

Editor's Notes — Laws of 2019, ch. 343, § 10, effective January 1, 2020, provides: "SECTION 10. This act shall take effect and be in force from and after January 1, 2020. The first filing of the CGAD shall be in 2020."

§ 83-5-703. Definitions.

As used in this article, unless the context requires otherwise:

(a) "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

(b) "Corporate Governance Annual Disclosure (CGAD)" means a confidential report filed by the insurer or insurance group made in accordance with the requirements of this article.

(c) "Insurance group" means those insurers and affiliates included within an insurance holding company system as defined in Section 83-6-1 et seq.

(d) "Insurer" shall have the same meaning as set forth in Section 83-6-1(e), except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(e) "NAIC" means the National Association of Insurance Commissioners.

(f) "ORSA Summary Report" means the report filed in accordance with Section 83-85-1 et seq.

HISTORY: Laws, 2019, ch. 343, § 2, eff from and after January 1, 2020.

Editor's Notes — Laws of 2019, ch. 343, § 10, effective January 1, 2020, provides: "SECTION 10. This act shall take effect and be in force from and after January 1, 2020. The first filing of the CGAD shall be in 2020."

§ 83-5-705. Disclosure requirement; permissible levels of reporting.

(1) An insurer, or the insurance group of which the insurer is a member, shall, no later than June 1 of each calendar year, submit to the commissioner a Corporate Governance Annual Disclosure (CGAD) that contains the information described in Section 83-5-709(2). Notwithstanding any request from the commissioner made pursuant to subsection (3) of this section, if the insurer is a member of an insurance group, the insurer shall submit the report required by this section to the commissioner of the lead state for the insurance group, in accordance with the laws of the lead state, as determined by the procedures outlined in the most recent Financial Analysis Handbook adopted by the NAIC.

(2) The CGAD must include a signature of the insurer or insurance group's chief executive officer or corporate secretary attesting to the best of that individual's belief and knowledge that the insurer has implemented the corporate governance practices and that a copy of the disclosure has been provided to the insurer's board of directors or the appropriate committee thereof.

(3) An insurer not required to submit a CGAD under this section shall do so upon the commissioner's request.

(4) For purposes of completing the CGAD, the insurer or insurance group may provide information regarding corporate governance at the ultimate controlling parent level, an intermediate holding company level and/or the individual legal entity level, depending upon how the insurer or insurance group has structured its system of corporate governance. The insurer or insurance group is encouraged to make the CGAD disclosures at the level at which the insurer's or insurance group's risk appetite is determined, or at which the earnings, capital, liquidity, operations, and reputation of the insurer are overseen collectively and at which the supervision of those factors are coordinated and exercised, or the level at which legal liability for failure of general corporate governance duties would be placed. If the insurer or insurance group determines the level of reporting based on these criteria, it

shall indicate which of the three (3) criteria was used to determine the level of reporting and explain any subsequent changes in the level of reporting.

(5) The review of the CGAD and any additional requests for information shall be made through the lead state as determined by the procedures within the most recent Financial Analysis Handbook referenced in subsection (1) of this section.

(6) Insurers providing information substantially similar to the information required by this article in other documents provided to the commissioner, including proxy statements filed in conjunction with Form B requirements, or other state or federal filings provided to this department shall not be required to duplicate that information in the CGAD, but shall only be required to cross reference the document in which the information is included.

HISTORY: Laws, 2019, ch. 343, § 3, eff from and after January 1, 2020.

Editor's Notes — Laws of 2019, ch. 343, § 10, effective January 1, 2020, provides: "SECTION 10. This act shall take effect and be in force from and after January 1, 2020. The first filing of the CGAD shall be in 2020."

§ 83-5-707. Promulgation of rules, regulations and orders.

The commissioner may, upon notice and opportunity for all interested persons to be heard, issue such rules, regulations and orders as shall be necessary to carry out the provisions of this article.

HISTORY: Laws, 2019, ch. 343, § 4, eff from and after January 1, 2020.

Editor's Notes — Laws of 2019, ch. 343, § 10, effective January 1, 2020, provides: "SECTION 10. This act shall take effect and be in force from and after January 1, 2020. The first filing of the CGAD shall be in 2020."

§ 83-5-709. Contents of corporate governance annual disclosure

(1) The insurer or insurance group shall have discretion over the responses to the CGAD inquiries, provided the CGAD shall contain the material information necessary to permit the commissioner to gain an understanding of the insurer's or group's corporate governance structure, policies and practices. The commissioner may request additional information that he or she deems material and necessary to provide the commissioner with a clear understanding of the corporate governance policies, the reporting or information system or controls implementing those policies.

(2) Notwithstanding subsection (1) of this section, the CGAD shall be prepared consistent with the NAIC Corporate Governance Annual Disclosure Model Regulation, as which may be adopted and amended. Documentation and supporting information shall be maintained and made available upon examination or upon request of the commissioner.

HISTORY: Laws, 2019, ch. 343, § 5, eff from and after January 1, 2020.

Editor's Notes — Laws of 2019, ch. 343, § 10, effective January 1, 2020, provides: "SECTION 10. This act shall take effect and be in force from and after January 1, 2020. The first filing of the CGAD shall be in 2020."

§ 83-5-711. Confidentiality.

(1) Documents, materials or other information including the CGAD, in the possession or control of the Department of Insurance that are obtained by, created by or disclosed to the commissioner or any other person under this article, are recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to the Mississippi Public Records Act, Section 25-61-1 et seq., shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer. Nothing in this section shall be construed to require written consent of the insurer before the commissioner may share or receive confidential documents, materials or other CGAD-related information pursuant to subsection (3) of this section to assist in the performance of the commissioner's regular duties.

(2) Neither the commissioner nor any person who received documents, materials or other CGAD-related information, through examination or otherwise, while acting under the authority of the commissioner, or with whom such documents, materials or other information are shared pursuant to this article shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the commissioner's regulatory duties, the commissioner:

(a) May, upon request, share documents, materials or other CGAD-related information including the confidential and privileged documents, materials or information subject to subsection (1) of this section, including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in Section 83-6-45(3), with the NAIC, and with third-party consultants pursuant to Section 83-5-713, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, material or other information and has verified in writing the legal authority to maintain confidentiality; and

(b) May receive documents, materials or other CGAD-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other state, federal and international financial regulatory agencies, including members of any supervisory college as defined in Section 83-6-45(3) and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

(4) The sharing of information and documents by the commissioner pursuant to this article shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this article.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other CGAD-related information shall occur as a result of disclosure of such CGAD-related information or documents to the commissioner under this section or as a result of sharing as authorized in this article.

HISTORY: Laws, 2019, ch. 343, § 6, eff from and after January 1, 2020.

Editor's Notes — Laws of 2019, ch. 343, § 10, effective January 1, 2020, provides: "SECTION 10. This act shall take effect and be in force from and after January 1, 2020. The first filing of the CGAD shall be in 2020."

§ 83-5-713. NAIC and third-party consultants.

(1) The commissioner may retain, at the insurer's expense, third-party consultants, including attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the CGAD and related information or the insurer's compliance with this article.

(2) Any persons retained under subsection (1) of this section shall be under the direction and control of the commissioner and shall act in a purely advisory capacity.

(3) The NAIC and third-party consultants shall be subject to the same confidentiality standards and requirements as the commissioner.

(4) As part of the retention process, a third-party consultant shall verify to the commissioner, with notice to the insurer, that it is free of a conflict of interest and that it has internal procedures in place to monitor compliance with a conflict and to comply with the confidentiality standards and requirements of this article.

(5) A written agreement with the NAIC and/or a third-party consultant governing the sharing and use of information provided pursuant to this article shall contain the following provisions and expressly require the written consent of the insurer prior to making public information provided under this article:

(a) Specific procedures and protocols for maintaining the confidentiality and security of CGAD-related information shared with the NAIC or a third-party consultant pursuant to this article;

(b) Procedures and protocols for sharing by the NAIC only with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the CGAD-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(c) A provision specifying that ownership of the CGAD-related information shared with the NAIC or a third-party consultant remains with the Department of Insurance and the NAIC's or third-party consultant's use of the information is subject to the direction of the commissioner;

(d) A provision that prohibits the NAIC or a third-party consultant from storing the information shared pursuant to this article in a permanent database after the underlying analysis is completed;

(e) A provision requiring the NAIC or third-party consultant to provide prompt notice to the commissioner and to the insurer or insurance group regarding any subpoena, request for disclosure, or request for production of the insurer's CGAD-related information; and

(f) A requirement that the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this article.

HISTORY: Laws, 2019, ch. 343, § 7, eff from and after January 1, 2020.

Editor's Notes — Laws of 2019, ch. 343, § 10, effective January 1, 2020, provides: "SECTION 10. This act shall take effect and be in force from and after January 1, 2020. The first filing of the CGAD shall be in 2020."

§ 83-5-715. Penalties for failure to file.

Any insurer failing, without just cause, to timely file the CGAD as required in this article shall be required, after notice and hearing, to pay a penalty of One Hundred Dollars ($100.00) for each day's delay, to be recovered by the commissioner and the penalty so recovered shall be paid into the State General Fund. The maximum penalty under this section is Ten Thousand Dollars ($10,000.00). The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

HISTORY: Laws, 2019, ch. 343, § 8, eff from and after January 1, 2020.

Editor's Notes — Laws of 2019, ch. 343, § 10, effective January 1, 2020, provides: "SECTION 10. This act shall take effect and be in force from and after January 1, 2020. The first filing of the CGAD shall be in 2020."

§ 83-5-717. Severability.

If any provision of this article, other than Section 83-5-711, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this article which can be given effect without the invalid provision or application, and to that end the provisions of this article, with the exception of Section 83-5-711, are severable.

HISTORY: Laws, 2019, ch. 343, § 9, eff from and after January 1, 2020.

Editor's Notes — Laws of 2019, ch. 343, § 10, effective January 1, 2020, provides: "SECTION 10. This act shall take effect and be in force from and after January 1, 2020. The first filing of the CGAD shall be in 2020.'

ARTICLE 11.

INSURANCE DATA SECURITY LAW

Sec.

83-5-801. Short title.
83-5-803. Article establishes exclusive state standards for data security, investigation of cybersecurity event, and notification to Commissioner of Insurance.
83-5-805. Definitions.
83-5-807. Development, implementation and maintenance of information security program.
83-5-809. Investigation of cybersecurity event.
83-5-811. Notification of cybersecurity event involving nonpublic information; information to be provided; investigation of cybersecurity event in system maintained by third-party service provider.
83-5-813. Power of commissioner to investigate licensee and enforce provisions of this article.
83-5-815. Protection of documents, materials and other information.
83-5-817. Exemptions.
83-5-819. Penalties for violation of article.
83-5-821. Regulations.
83-5-823. Severability.
83-5-825. Implementation of Section 83-5-807 and Section 83-5-807(6).

§ 83-5-801. Short title.

This article shall be known and may be cited as the "Insurance Data Security Law."

HISTORY: Laws, 2019, ch. 448, § 1, eff from and after July 1, 2019.

§ 83-5-803. Article establishes exclusive state standards for data security, investigation of cybersecurity event, and notification to Commissioner of Insurance.

(1) Notwithstanding any other provision of law, this article establishes the exclusive state standards applicable to licensees for data security, the investigation of a cybersecurity event as defined in Section 83-5-805, and notification to the Commissioner of Insurance.

(2) This article may not be construed to create or imply a private cause of action for violation of its provisions nor may it be construed to curtail a private cause of action which would otherwise exist in the absence of this article.

HISTORY: Laws, 2019, ch. 448, § 2, eff from and after July 1, 2019.

§ 83-5-805. Definitions.

As used in this article, the following terms shall have the following meanings:

(a) "Authorized individual" means an individual known to and screened by the licensee and determined to be necessary and appropriate to have access to the nonpublic information held by the licensee and its information systems.

(b) "Commissioner" means the Commissioner of Insurance.

(c) "Consumer" means an individual, including, but not limited to, applicants, policyholders, insureds, beneficiaries, claimants and certificate holders, who is a resident of this state and whose nonpublic information is in a licensee's possession, custody or control.

(d) "Cybersecurity event" means an event resulting in unauthorized access to, disruption or misuse of, an information system or nonpublic information stored on such information system. The term "cybersecurity event" does not include the unauthorized acquisition of encrypted nonpublic information if the encryption, process or key is not also acquired, released or used without authorization. "Cybersecurity event" does not include an event with regard to which the licensee has determined that the nonpublic information accessed by an unauthorized person has not been used or released and has been returned or destroyed.

(e) "Department" means the Mississippi Insurance Department.

(f) "Encrypted" means the transformation of data into a form which results in a low probability of assigning meaning without the use of a protective process or key.

(g) "Information security program" means the administrative, technical and physical safeguards that a licensee uses to access, collect, distribute, process, protect, store, use, transmit, dispose of or otherwise handle nonpublic information.

(h) "Information system" means a discrete set of electronic information resources organized for the collection, processing, maintenance, use, sharing, dissemination or disposition of electronic nonpublic information, as well as any specialized system such as industrial/process controls systems, telephone switching and private branch exchange systems, and environmental control systems.

(i) "Licensee" means any person licensed, authorized to operate, or registered, or required to be licensed, authorized or registered pursuant to the insurance laws of this state, but shall not include a purchasing group or a risk-retention group chartered and licensed in a state other than this state or a person who is acting as an assuming insurer that is domiciled in another state or jurisdiction.

(j) "Multi-factor authentication" means authentication through verification of at least two (2) of the following types of authentication factors:

(i) Knowledge factors, such as a password;

(ii) Possession factors, such as a token or text message on a mobile phone; or

(iii) Inherence factors, such as a biometric characteristic.

(k) "Nonpublic information" means electronic information that is not publicly available information and is:

(i) Any information concerning a consumer which because of name, number, personal mark or other identifier can be used to identify such consumer, in combination with any one or more of the following data elements:

1. Social security number;
2. Driver's license number or nondriver identification card number;
3. Financial account number, credit or debit card number;
4. Any security code, access code or password that would permit access to a consumer's financial account; or
5. Biometric records;

(ii) Any information or data, except age or gender, in any form or medium created by or derived from a health care provider or a consumer, that can be used to identify a particular consumer, and that relates to:

1. The past, present or future physical, mental or behavioral health or condition of any consumer or a member of the consumer's family;
2. The provision of health care to any consumer; or
3. Payment for the provision of health care to any consumer.

(*l*) "Person" means any individual or any nongovernmental entity, including, but not limited to, any nongovernmental partnership, corporation, branch, agency or association.

(m) "Publicly available information" means any information that a licensee has a reasonable basis to believe is lawfully made available to the general public from: federal, state or local government records; widely distributed media; or disclosures to the general public that are required to be made by federal, state or local law. For the purposes of this definition, a licensee has a reasonable basis to believe that information is lawfully made available to the general public if the licensee has taken steps to determine:

(i) That the information is of the type that is available to the general public; and

(ii) Whether a consumer can direct that the information not be made available to the general public and, if so, that such consumer has not done so.

(n) "Risk assessment" means the risk assessment that each licensee is required to conduct under Section 83-5-807(3).

(o) "State" means the State of Mississippi.

(p) "Third-party service provider" means a person, not otherwise defined as a licensee, who contracts with a licensee to maintain, process, store or otherwise is permitted access to nonpublic information through its provision of services to the licensee.

HISTORY: Laws, 2019, ch. 448, Laws, 2019, ch. 448, § 3, eff from and after July 1, 2019., eff from and after July 1, 2019.

RESEARCH REFERENCES

Practice References.
Cyber Risks, Social Media and Insurance: A Guide to Risk Assessment and Management, Carrie E. Cope, Esq., Dirk E. Ehlers, Keith W. Mandell.

§ 83-5-807. Development, implementation and maintenance of information security program.

(1) Commensurate with the size and complexity of the licensee, the nature and scope of the licensee's activities, including its use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody or control, each licensee shall develop, implement, and maintain a comprehensive written information security program based on the licensee's risk assessment and that contains administrative, technical and physical safeguards for the protection of nonpublic information and the licensee's information system.

(2) A licensee's information security program shall be designed to:

(a) Protect the security and confidentiality of nonpublic information and the security of the information system;

(b) Protect against any threats or hazards to the security or integrity of nonpublic information and the information system;

(c) Protect against unauthorized access to or use of nonpublic information, and minimize the likelihood of harm to any consumer; and

(d) Define and periodically reevaluate a schedule for retention of nonpublic information and a mechanism for its destruction when no longer needed.

(3) The licensee shall:

(a) Designate one or more employees, an affiliate, or an outside vendor designated to act on behalf of the licensee who is responsible for the information security program;

(b) Identify reasonably foreseeable internal or external threats that could result in unauthorized access, transmission, disclosure, misuse, alteration or destruction of nonpublic information, including the security of information systems and nonpublic information that are accessible to, or held by, third-party service providers;

(c) Assess the likelihood and potential damage of these threats, taking into consideration the sensitivity of the nonpublic information;

(d) Assess the sufficiency of policies, procedures, information systems and other safeguards in place to manage these threats, including consideration of threats in each relevant area of the licensee's operations, including:

(i) Employee training and management;

(ii) Information systems, including network and software design, as well as information classification, governance, processing, storage, transmission and disposal; and

(iii) Detecting, preventing and responding to attacks, intrusions or other systems failures; and

(e) Implement information safeguards to manage the threats identified in its ongoing assessment, and no less than annually, assess the effectiveness of the safeguards' key controls, systems and procedures.

(4) Based on its risk assessment, the licensee shall:

(a) Design its information security program to mitigate the identified risks, commensurate with the size and complexity of the licensee, the nature and scope of the licensee's activities, including its use of third-party service providers, and the sensitivity of the nonpublic information used by the licensee or in the licensee's possession, custody or control.

(b) Determine which security measures listed below are appropriate and implement such security measures.

(i) Place access controls on information systems, including controls to authenticate and permit access only to authorized individuals to protect against the unauthorized acquisition of nonpublic information;

(ii) Identify and manage the data, personnel, devices, systems and facilities that enable the organization to achieve business purposes in accordance with their relative importance to business objectives and the organization's risk strategy;

(iii) Restrict physical access to nonpublic information, only to authorized individuals;

(iv) Protect by encryption or other appropriate means, all nonpublic information while being transmitted over an external network and all nonpublic information stored on a laptop computer or other portable computing or storage device or media;

(v) Adopt secure development practices for in-house developed applications utilized by the licensee;

(vi) Modify the information system in accordance with the licensee's information security program;

(vii) Utilize effective controls, which may include multi-factor authentication procedures for employees accessing nonpublic information;

(viii) Regularly test and monitor systems and procedures to detect actual and attempted attacks on, or intrusions into, information systems;

(ix) Include audit trails within the information security program designed to detect and respond to cybersecurity events and designed to reconstruct material financial transactions sufficient to support normal operations and obligations of the licensee;

(x) Implement measures to protect against destruction, loss, or damage of nonpublic information due to environmental hazards, such as fire and water damage or other catastrophes or technological failures; and

(xi) Develop, implement, and maintain procedures for the secure disposal of nonpublic information in any format.

(c) Include cybersecurity risks in the licensee's enterprise risk management process.

(d) Stay informed regarding emerging threats or vulnerabilities and utilize reasonable security measures when sharing information relative to the character of the sharing and the type of information shared.

(e) Provide its personnel with cybersecurity awareness training that is updated as necessary to reflect risks identified by the licensee in the risk assessment.

(5) If the licensee has a board of directors, the board or an appropriate committee of the board shall, at a minimum:

(a) Require the licensee's executive management or its delegates to develop, implement and maintain the licensee's information security program;

(b) Require the licensee's executive management or its delegates to report in writing at least annually, the following information:

(i) The overall status of the information security program and the licensee's compliance with this article; and

(ii) Material matters related to the information security program, addressing issues such as risk assessment, risk management and control decisions, third-party service provider arrangements, results of testing, cybersecurity events or violations and management's responses thereto, and recommendations for changes in the information security program;

(c) If executive management delegates any of its responsibilities under this section, it shall oversee the development, implementation and maintenance of the licensee's information security program prepared by the delegate(s) and shall receive a report from the delegate(s) complying with the requirements of the report to the board of directors above.

(6)(a) A licensee shall exercise due diligence in selecting its third-party service provider; and

(b) A licensee shall require a third-party service provider to implement appropriate administrative, technical and physical measures to protect and secure the information systems and nonpublic information that are accessible to, or held by, the third-party service provider.

(7) The licensee shall monitor, evaluate and adjust, as appropriate, the information security program consistent with any relevant changes in technology, the sensitivity of its nonpublic information, internal or external threats to information, and the licensee's own changing business arrangements, such as mergers and acquisitions, alliances and joint ventures, outsourcing arrangements and changes to information systems.

(8)(a) As part of its information security program, each licensee shall establish a written incident response plan designed to promptly respond to, and recover from, any cybersecurity event that compromises the confidentiality, integrity or availability of nonpublic information in its possession, the licensee's information systems, or the continuing functionality of any aspect of the licensee's business or operations.

(b) Such incident response plan shall address the following areas:

(i) The internal process for responding to a cybersecurity event;

(ii) The goals of the incident response plan;

(iii) The definition of clear roles, responsibilities and levels of decision-making authority;

(iv) External and internal communications and information sharing;

(v) Identification of requirements for the remediation of any identified weaknesses in information systems and associated controls;

(vi) Documentation and reporting regarding cybersecurity events and related incident response activities; and

(vii) The evaluation and revision as necessary of the incident response plan following a cybersecurity event.

(9) Annually, each insurer domiciled in this state shall submit to the commissioner a written statement by February 15, certifying that the insurer is in compliance with the requirements set forth in this section. Each insurer shall maintain for examination by the department all records, schedules and data supporting this certificate for a period of five (5) years. To the extent an insurer has identified areas, systems or processes that require material improvement, updating or redesign, the insurer shall document the identification and the remedial efforts planned and underway to address such areas, systems or processes. Such documentation must be available for inspection by the commissioner.

HISTORY: Laws, 2019, ch. 448, § 4, eff from and after July 1, 2019.

§ 83-5-809. Investigation of cybersecurity event.

(1) If the licensee learns that a cybersecurity event has or may have occurred, then the licensee, or an outside vendor and/or service provider designated to act on behalf of the licensee, shall conduct a prompt investigation.

(2) During the investigation, the licensee, or an outside vendor and/or service provider designated to act on behalf of the licensee, shall, at a minimum, determine as much of the following information as possible:

(a) Determine whether a cybersecurity event has occurred;

(b) Assess the nature and scope of the cybersecurity event;

(c) Identify any nonpublic information that may have been involved in the cybersecurity event; and

(d) Perform or oversee reasonable measures to restore the security of the information systems compromised in the cybersecurity event in order to prevent further unauthorized acquisition, release or use of nonpublic information in the licensee's possession, custody or control.

(3) If the licensee learns that a cybersecurity event has or may have occurred in a system maintained by a third-party service provider, the licensee will complete the steps listed in subsection (2) of this section or confirm and document that the third-party service provider has completed those steps.

(4) The licensee shall maintain records concerning all cybersecurity events for a period of at least five (5) years from the date of the cybersecurity event and shall produce those records upon demand of the commissioner.

HISTORY: Laws, 2019, ch. 448, § 5, eff from and after July 1, 2019.

§ 83-5-811. Notification of cybersecurity event involving nonpublic information; information to be provided; investigation of cybersecurity event in system maintained by third-party service provider.

(1) Each licensee shall notify the commissioner as promptly as possible but in no event later than three (3) business days from a determination that a cybersecurity event involving nonpublic information that is in the possession of a licensee has occurred when either of the following criteria has been met:

(a) This state is the licensee's state of domicile, in the case of an insurer, or this state is the licensee's home state, in the case of a producer, as those terms are defined in Section 83-17-53, and the cybersecurity event has a reasonable likelihood of materially harming a consumer residing in this state or reasonable likelihood of materially harming any material part of the normal operation(s) of the licensee; or

(b) The licensee reasonably believes that the nonpublic information involved is of two hundred fifty (250) or more consumers residing in this state and that is either of the following:

(i) A cybersecurity event impacting the licensee of which notice is required to be provided to any government body, self-regulatory agency or any other supervisory body pursuant to any state or federal law; or

(ii) A cybersecurity event that has a reasonable likelihood of materially harming:

1. Any consumer residing in this state; or
2. Any material part of the normal operation(s) of the licensee.

(2) The licensee shall provide as much of the following information as possible. The licensee shall provide the information in electronic form as directed by the commissioner. The licensee shall have a continuing obligation to update and supplement initial and subsequent notifications to the commissioner regarding material changes to previously provided information relating to the cybersecurity event.

(a) Date of the cybersecurity event;

(b) Description of how the information was exposed, lost, stolen or breached, including the specific roles and responsibilities of third-party service providers, if any;

(c) How the cybersecurity event was discovered;

(d) Whether any lost, stolen, or breached information has been recovered and if so, how this was done;

(e) The identity of the source of the cybersecurity event;

(f) Whether the licensee has filed a police report or has notified any regulatory, government or law enforcement agencies and, if so, when such notification was provided;

(g) Description of the specific types of information acquired without authorization. Specific types of information means particular data elements including, for example, types of medical information, types of financial information or types of information allowing identification of the consumer;

(h) The period during which the information system was compromised by the cybersecurity event;

(i) The number of total consumers in this state affected by the cybersecurity event. The licensee shall provide the best estimate in the initial report to the commissioner and update this estimate with each subsequent report to the commissioner pursuant to this section;

(j) The results of any internal review identifying a lapse in either automated controls or internal procedures, or confirming that all automated controls or internal procedures were followed;

(k) Description of efforts being undertaken to remediate the situation which permitted the cybersecurity event to occur;

(*l*) A copy of the licensee's privacy policy and a statement outlining the steps the licensee will take to investigate and notify consumers affected by the cybersecurity event; and

(m) Name of a contact person who is both familiar with the cybersecurity event and authorized to act for the licensee.

(3) Licensee shall comply with Section 75-24-29, as applicable, and provide a copy of the notice sent to consumers under that statute to the commissioner, when a licensee is required to notify the commissioner under subsection (1) of this section.

(4)(a) In the case of a cybersecurity event in a system maintained by a third-party service provider, of which the licensee has become aware, the licensee shall treat such event as it would under subsection (1) of this section unless the third-party service provider provides the notice required under subsection (1) of this section to the commissioner.

(b) The computation of licensee's deadlines shall begin on the day after the third-party service provider notifies the licensee of the cybersecurity event or the licensee otherwise has actual knowledge of the cybersecurity event, whichever is sooner.

(c) Nothing in this article shall prevent or abrogate an agreement between a licensee and another licensee, a third-party service provider or any other party to fulfill any of the investigation requirements imposed under Section 83-5-809 or notice requirements imposed under this section.

(5)(a)(i) In the case of a cybersecurity event involving nonpublic information that is used by the licensee who is acting as an assuming insurer or in the possession, custody or control of a licensee who is acting as an assuming insurer and that does not have a direct contractual relationship with the affected consumers, the assuming insurer shall notify its affected ceding insurers and the commissioner of its state of domicile within three (3) business days of making the determination that a cybersecurity event has occurred.

(ii) The ceding insurers that have a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under Section 75-24-29 and any other notification requirements relating to a cybersecurity event imposed under this section.

(b)(i) In the case of a cybersecurity event involving nonpublic information that is in the possession, custody or control of a third-party service provider of a licensee who is an assuming insurer, the assuming insurer shall notify its affected ceding insurers and the commissioner of its state of domicile within three (3) business days of receiving notice from its third-party service provider that a cybersecurity event has occurred.

(ii) The ceding insurers that have a direct contractual relationship with affected consumers shall fulfill the consumer notification requirements imposed under Section 75-24-29 and any other notification requirements relating to a cybersecurity event imposed under this section.

(c) Any licensee acting as assuming insurer shall have no other notice obligations relating to a cybersecurity event or other data breach under this section or any other law of this state.

(6) In the case of a cybersecurity event involving nonpublic information that is in the possession, custody or control of a licensee who is an insurer or its third-party service provider for which a consumer accessed the insurer's services through an independent insurance producer, and for which consumer notice is required under Section 75-24-29, the insurer shall notify the producers of record of all affected consumers of the cybersecurity event no later than the time at which notice is provided to the affected consumers. The insurer is excused from this obligation for any producers who are not authorized by law or contract to sell, solicit or negotiate on behalf of the insurer, and in those instances in which the insurer does not have the current producer of record information for any individual consumer.

HISTORY: Laws, 2019, ch. 448, § 6, eff from and after July 1, 2019.

§ 83-5-813. Power of commissioner to investigate licensee and enforce provisions of this article.

(1) The commissioner shall have power to examine and investigate into the affairs of any licensee to determine whether the licensee has been or is engaged in any conduct in violation of this article. This power is in addition to the powers which the commissioner has under Section 83-5-201 et seq. Any such investigation or examination shall be conducted pursuant to Section 83-5-201 et seq.

(2) Whenever the commissioner has reason to believe that a licensee has been or is engaged in conduct in this state which violates this article, the commissioner may take action that is necessary or appropriate to enforce the provisions of this article.

HISTORY: Laws, 2019, ch. 448, § 7, eff from and after July 1, 2019.

§ 83-5-815. Protection of documents, materials and other information.

(1) Any documents, materials or other information in the control or possession of the department that are furnished by a licensee or an employee or agent thereof acting on behalf of a licensee pursuant to Section 83-5-807(9),

Section 83-5-811(2)(b), (c), (d), (e), (h), (j) and (k) or that are obtained by the commissioner in an investigation or examination pursuant to Section 83-5-813, shall be confidential by law and privileged, shall not be subject to the Mississippi Public Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the licensee.

(2) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the commissioner's duties under this article, the commissioner:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (1) of this section, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information;

(b) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information;

(c) May share documents, materials or other information subject to subsection (1) of this section with a third-party consultant or vendor provided the consultant agrees in writing to maintain the confidentiality and privileged status of the document, material or other information; and

(d) May enter into agreements governing sharing and use of information consistent with this subsection (3).

(4) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (3) of this section.

(5) Nothing in this article shall prohibit the commissioner from releasing final, adjudicated actions that are open to public inspection pursuant to the Mississippi Public Records Act, to a database or other clearinghouse service

maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

(6) Documents, materials or other information in the possession or control of the National Association of Insurance Commissioners or a third-party consultant or vendor pursuant to this article shall be confidential by law and privileged, shall not be subject to the Mississippi Public Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

HISTORY: Laws, 2019, ch. 448, Laws, 2019, ch. 448, § 8, eff from and after July 1, 2019., eff from and after July 1, 2019.

Cross References — Mississippi Public Records Act, see § 25-61-1 et seq.

§ 83-5-817. Exemptions.

(1) The following exceptions shall apply to this article:

(a) A licensee meeting any of the following criteria is exempt from Sections 83-5-807, 83-5-809(3) and 83-5-811(4)(a) and (b):

(i) Fewer than fifty (50) employees, excluding any independent contractors;

(ii) Less than Five Million Dollars ($5,000,000.00) in gross annual revenue;

(iii) Less than Ten Million Dollars ($10,000,000.00) in year-end total assets; or

(iv) Insurance producers and adjusters.

(b) A licensee subject to Public Law 104-191, 110 Stat. 1936, enacted August 21, 1996, (Health Insurance Portability and Accountability Act) that has established and maintains an information security program pursuant to such statutes, rules, regulations, procedures or guidelines established thereunder, will be considered to meet the requirements of Section 83–5–807, provided that the licensee is compliant with, and submits a written statement certifying its compliance with, the same.

(c) An employee, agent, representative or designee of a licensee, who is also a licensee, is exempt from Section 83-5-807 and need not develop its own information security program to the extent that the employee, agent, representative or designee is covered by the information security program of the other licensee.

(d) A licensee affiliated with a depository institution that maintains an information security program in compliance with the *Interagency Guidelines Establishing Standards for Safeguarding Customer Information* as set forth pursuant to Sections 501 and 505 of the Gramm-Leach-Bliley Act (15 U.S.C. 6801 and 6805) shall be considered to meet the requirements of Section 83-5-807, provided that the licensee produces, upon request, documentation satisfactory to the commissioner that independently validates the affiliated depository institution's adoption of an information security program that satisfies the Interagency Guidelines.

(2) In the event that a licensee ceases to qualify for an exception, such licensee shall have one hundred eighty (180) days to comply with this article.

HISTORY: Laws, 2019, ch. 448, § 9, eff from and after July 1, 2019.

§ 83-5-819. Penalties for violation of article.

In the case of a violation of this article, a licensee may be penalized in accordance with Section 83-5-85.

HISTORY: Laws, 2019, ch. 448, § 10, eff from and after July 1, 2019.

§ 83-5-821. Regulations.

The commissioner may issue such regulations as shall be necessary to carry out the provisions of this article.

HISTORY: Laws, 2019, ch. 448, § 11, eff from and after July 1, 2019.

§ 83-5-823. Severability.

If any provisions of this article or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the article and the application of such provision to other persons or circumstances shall not be affected thereby.

HISTORY: Laws, 2019, ch. 448, § 12, eff from and after July 1, 2019.

§ 83-5-825. Implementation of Section 83-5-807 and Section 83-5-807(6).

Licensees shall have one (1) year from July 1, 2019, to implement Section 83-5-807 and two (2) years from July 1, 2019 to implement Section 83-5-807(6).

HISTORY: Laws, 2019, ch. 448, § 13, eff from and after July 1, 2019.

ARTICLE 13

MISSISSIPPI INSURANCE E-COMMERCE MODEL ACT

Sec.
83-5-851. Short title.
83-5-853. Purpose.
83-5-855. Definitions.
83-5-857. Delivery, storage or presentation of notice or other documents required by law in insurance transactions or serving as evidence of insurance coverage by electronic means; consent of party to electronic delivery.
83-5-859. Notice to party of changes in hardware or software requirements for access to notices or documents delivered electronically.
83-5-861. Relation of section to other law; confirmation of receipt of notice or document delivered electronically; applicability of article.

Sec.
83-5-863. Effect of insurer's failure to obtain electronic consent or confirmation of consent on effectiveness, validity or enforceability of contract or policy.
83-5-865. Withdrawal of consent to receive electronic notices or documents.
83-5-867. Notice requirement if consent of party to receive notices or documents electronically was on file before July 1, 2022.
83-5-869. Conditions under which insurer shall deliver notice or document by means other than electronic delivery.
83-5-871. Immunity of insurance producers from civil liability.
83-5-873. Posting of certain insurance policies and endorsements on insurer's website under certain circumstances.
83-5-875. Payment of claims brought by insureds, workers' compensation claimants or third parties against insurer.
83-5-877. Adoption of rules to implement provisions of article.

§ 83-5-851. Short title

This article shall be known as the "Mississippi Insurance E-Commerce Model Act."

HISTORY: Laws, 2022, ch. 374, § 1, eff from and after July 1, 2022.

§ 83-5-853. Purpose.

The purpose of this article is to provide consumers more choice, convenience and flexibility in managing their insurance.

HISTORY: Laws, 2022, ch. 374, § 2, eff from and after July 1, 2022.

§ 83-5-855. Definitions.

As used in this article, the following definitions apply:

(a) "Delivered by electronic means" means either of the following:

(i) Delivery to an electronic mail address at which a party has consented to receive notices or documents; or

(ii) Posting on an electronic network or site accessible via the Internet, mobile application, computer, mobile device, tablet, or any other electronic device, together with separate notice of the posting provided by electronic mail to the address at which the party has consented to receive notice or by any other delivery method that has been consented to by the party. The separate notice of the posting shall contain the Internet address at which the documents are posted. For purposes of this subsection, delivery shall be effective upon the latter of the posting or the actual delivery of the separate notice of the posting.

(b) "Party" means any recipient of any notice or document required as part of an insurance transaction, including, but not limited to, an applicant, an insured, a policyholder, or an annuity contract holder.

HISTORY: Laws, 2022, ch. 374, § 3, eff from and after July 1, 2022.

§ 83-5-857. Delivery, storage or presentation of notice or other documents required by law in insurance transactions or serving as evidence of insurance coverage by electronic means; consent of party to electronic delivery.

(1) Subject to the requirements of this section, any notice to a party or any other document required by law in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored, and presented by electronic means if the electronic means meet the requirements of applicable state technology law.

(2) Delivery of a notice or document in accordance with this section shall be considered equivalent to and have the same effect as any delivery method required by law, including delivery by first class mail, first class mail with postage prepaid, certified mail, certificate of mail, or certificate of mailing.

(3) A notice or document may be delivered by electronic means by an insurer to a party pursuant to this section if all of the following apply:

(a) The party has affirmatively consented electronically, or confirmed consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means to which the party has given consent, and the party has not withdrawn the consent.

(b) The party, before giving consent, is provided with a clear and conspicuous statement informing the party of all of the following:

(i) The hardware and software requirements for access to and retention of a notice or document delivered by electronic means.

(ii) The types of notices and documents to which the party's consent would apply.

(iii) The right of the party to withdraw consent to have a notice or document delivered by electronic means, at any time, and any conditions or consequences imposed in the event consent is withdrawn.

(iv) The procedures a party must follow to withdraw consent, which can be no more burdensome than providing consent, to have a notice or document delivered by electronic means and to update the party's electronic mail address.

(v) The right of a party to have any notice or document delivered, upon request, in paper form.

(4) An insurer shall take all measures reasonably calculated to ensure that delivery by electronic means pursuant to this section results in receipt of the notice or document by the party.

HISTORY: Laws, 2022, ch. 374, § 4, eff from and after July 1, 2022.

§ 83-5-859. Notice to party of changes in hardware or software requirements for access to notices or documents delivered electronically.

After the consent of a party is given, in the event a change in the hardware or software requirements needed to access or retain a notice or document to be delivered by electronic means creates a material risk that the party will not be able to access or retain the notice or document to which the consent applies, the insurer shall not deliver a notice or document to the party by electronic means unless the insurer complies with Section 83-5-857 and provides the party with a statement that describes all of the following:

(a) The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means.

(b) The right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

HISTORY: Laws, 2022, ch. 374, § 5, eff from and after July 1, 2022.

§ 83-5-861. Relation of section to other law; confirmation of receipt of notice or document delivered electronically; applicability of article.

(1) The provisions of this section shall not be construed to affect requirements related to content or timing of any notice or document required by any other provision of law.

(2) If a provision of this title or other applicable law requiring a notice or document to be provided to a party expressly requires confirmation of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for confirmation of receipt by the recipient.

(3) This article shall not apply to a notice or document delivered by an insurer in an electronic form before July 1, 2022, to a party who, before that date, has consented to receive the notice or document in an electronic form otherwise allowed by law.

HISTORY: Laws, 2022, ch. 374, § 6, eff from and after July 1, 2022.

§ 83-5-863. Effect of insurer's failure to obtain electronic consent or confirmation of consent on effectiveness, validity or enforceability of contract or policy.

The legal effectiveness, validity or enforceability of any contract or policy of insurance executed by a party shall not be denied solely because of the failure of the insurer to obtain electronic consent or confirmation of consent of the party in accordance with the provisions of this article if the notice or document is delivered in paper form.

HISTORY: Laws, 2022, ch. 374, § 7, eff from and after July 1, 2022.

§ 83-5-865. Withdrawal of consent to receive electronic notices or documents.

(1) A withdrawal of consent by a party shall not affect the legal effective-

ness, validity or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

(2) A withdrawal of consent by a party shall be effective within a reasonable period of time after receipt of the withdrawal by the insurer.

(3) Failure by an insurer to comply with any provision of Section 83-5-857 or 83-5-859 may be treated, at the election of the party, as a withdrawal of consent for purposes of this article.

HISTORY: Laws, 2022, ch. 374, § 8, eff from and after July 1, 2022.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section" for "Sections" near the middle of (3). The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-5-867. Notice requirement if consent of party to receive notices or documents electronically was on file before July 1, 2022.

If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before July 1, 2022, and an insurer intends to deliver additional notices or documents to the party in an electronic form pursuant to this article, then prior to delivering the additional notices or documents electronically, the insurer shall comply with the provisions of Section 83-5-857 and shall provide the party with a statement that describes both of the following:

(a) The notices or documents that shall be delivered by electronic means that were not previously delivered electronically.

(b) The party's right to withdraw consent to have notices or documents delivered by electronic means, without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

HISTORY: Laws, 2022, ch. 374, § 9, eff from and after July 1, 2022.

§ 83-5-869. Conditions under which insurer shall deliver notice or document by means other than electronic delivery.

An insurer shall deliver a notice or document by any other delivery method permitted by law other than electronic means if either of the following occurs:

(a) The insurer attempts to deliver the notice or document by electronic means and has a reasonable basis for believing that the notice or document has not been received by the party.

(b) The insurer becomes aware that the electronic mail address provided by the party is no longer valid. The insured's consent to electronic delivery shall not preclude the insurer from delivering a notice or document by any other delivery method permitted by law.

HISTORY: Laws, 2022, ch. 374, § 10, eff from and after July 1, 2022.

§ 83-5-871. Immunity of insurance producers from civil liability.

An insurance producer shall not be subject to civil liability for any harm or injury that occurs because of a party's election to receive any notice or document by electronic means or by an insurer's failure to deliver or a party's failure to receive a notice or document by electronic means.

HISTORY: Laws, 2022, ch. 374, § 11, eff from and after July 1, 2022.

§ 83-5-873. Posting of certain insurance policies and endorsements on insurer's website under certain circumstances.

(1) An insurance policy and an endorsement that does not contain personally identifiable information may be mailed, delivered, or, if the insurer obtains separate, specific consent, posted on the insurer's website. If the insurer elects to post an insurance policy and an endorsement on the insurer's website in lieu of mailing or delivering the policy and endorsement to the insured, the insurer shall comply with the following conditions:

(a) The policy and an endorsement must be accessible to the owner or insured and producer of record and remain that way while the policy is in force;

(b) After the expiration of the policy, the insurer shall either:

(i) Make the expired policy and endorsement available upon request, for a period of five (5) years; or

(ii) If the insurer continues to make the expired policy or endorsement available on its website, keep the insured's user ID active for a period of five (5) years;

(c) The policy and endorsement must be posted in a manner that enables the insured and producer of record to print and save the policy and endorsement using a program or application that is widely available on the Internet and free to use;

(d) The insurer shall provide the following information in, or simultaneous with, each declaration page provided at the time of issuance of the initial policy and any renewals of the policy:

(i) A description of the exact policy and endorsement form purchased by the insured;

(ii) A description of the insured's right to receive, upon request and without charge, an electronic and/or a paper copy of the policy and endorsement; and

(iii) The Internet address at which the policy and endorsement are posted;

(e) The insurer, upon an insured's request and once without charge following receipt of the initial copy, shall mail a paper copy of the policy and endorsement to the insured; and

(f) The insurer shall provide notice, either electronically or in writing at the insured's option, of any change to the forms or endorsement; the insured's right to obtain, upon request and once without charge following receipt of the initial copy, a paper copy of the forms or endorsement; and the Internet address at which the forms or endorsement are posted.

(2) This section does not affect the timing or content of any disclosure or document required to be provided or made available to any insured under applicable law.

HISTORY: Laws, 2022, ch. 374, § 12, eff from and after July 1, 2022.

§ 83-5-875. Payment of claims brought by insureds, workers' compensation claimants or third parties against insurer.

All claims brought by insureds, workers' compensation claimants, or third parties against an insurer shall be paid by check or draft of the insurer or, if offered by the insurer and the claimant consents, electronic transfer of funds to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or her/his attorney, or upon direction of the claimant to one specified. However, when the employer has advanced the claims payment to the claimant, the check or draft shall be paid jointly to the claimant and the employer; or, if consented by all parties, the electronic payment shall be paid to the trust account. The check or draft shall be paid jointly until the amount of the advanced claims payment has been recovered by the employer. The electronic payment shall be held in trust until the amount of the advanced claims payment has been recovered by the employer.

HISTORY: Laws, 2022, ch. 374, § 13, eff from and after July 1, 2022.

§ 83-5-877. Adoption of rules to implement provisions of article.

The Commissioner of Insurance may adopt rules to implement the provisions of this article.

HISTORY: Laws, 2022, ch. 374, § 14, eff from and after July 1, 2022.

CHAPTER 6.

REGISTRATION AND EXAMINATION OF INSURERS

Sec.

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83-6-5. Registration statement; filing, form and contents; annual enterprise risk report.
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83-6-35. Willful violations; criminal proceedings; punishment.
83-6-37. When commissioner may take possession and conduct business of domestic insurer.
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83-6-39. Suspension, revocation or refusal to renew license or certificate of authority.
83-6-41. Appeals to chancery court; petition for writ in nature of mandamus or peremptory mandamus.
83-6-43. Certain laws superseded; remedies to be construed as supplemental.
83-6-45. Supervisory colleges.
83-6-47. Group-wide supervision of internationally active insurance groups.

§ 83-6-1. Definitions.

As used in this chapter the following terms have the respective meanings herein set forth unless the context shall require otherwise:

(a) An "affiliate of" or person "affiliated" with a specific person means a person that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

(b) "Commissioner" means the Commissioner of Insurance.

(c) "Control" (including the terms "controlling," "controlled by" and "under common control with") means the possession of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services or otherwise, unless the power is the result of an official position with or corporate office held by the person. "Control" shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing made in the manner provided in Section 83-6-17 that control does not exist in fact. The commissioner may determine, after furnishing all persons in interest notice and opportunity to be heard and making specific findings of fact to support such determination, that control exists in fact, notwithstanding the absence of a presumption to that effect.

(d) An "insurance holding company system" consists of two (2) or more affiliated persons, one or more of which is an insurer.

(e) "Insurer" means only those companies subject to the jurisdiction of the commissioner as provided in Section 83-5-1; however, burial associations regulated pursuant to Chapter 37, Title 83, Mississippi Code of 1972, are excluded from this definition.

(f) "Person" means an individual, corporation, partnership, association, joint-stock company, trust, unincorporated organization, any similar entity or any combination of the foregoing acting in concert, but shall not include any securities broker performing no more than the usual and customary broker's function.

(g) A "security holder" of a specified person means one who owns any security of such person, including common stock, preferred stock, debt obligations and any other security convertible into or evidencing the right to acquire any of the foregoing.

(h) "Subsidiary" of a specified person means an affiliate controlled by a person, directly or indirectly, through one or more intermediaries.

(i) The term "voting security" includes any security convertible into or evidencing a right to acquire a voting security.

(j) "Enterprise risk" shall mean any activity, circumstance, event or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including, but not limited to, anything that would cause the insurer's Risk-Based Capital to fall into company action level as provided in Section 83-5-405 or would cause the insurer to be in hazardous financial condition as provided in Part 1, Chapter 39, Title 19 of the Mississippi Administrative Code.

(k) "Group-wide supervisor" means the regulatory official authorized to engage in conducting and coordinating group-wide supervision activities who is determined or acknowledged by the commissioner under Section 83-6-47 to have sufficient significant contacts with the internationally active insurance group.

(*l*) "Internationally active insurance group" means an insurance holding company system that:

(i) Includes an insurer registered under Section 83-6-3; and

(ii) Meets the following criteria:

1. Premiums written in at least three (3) countries;

2. The percentage of gross premiums written outside the United States is at least ten percent (10%) of the insurance holding company system's total gross written premiums; and

3. Based on a three-year rolling average, the total assets of the insurance holding company system are at least Fifty Billion ($50,000,000,000.00) or the total gross written premiums of the insurance holding company system are at least Ten Billion Dollars ($10,000,000,000.00).

HISTORY: Laws, 1974, ch. 366, § 1; Laws, 1992, ch. 573, § 1; Laws, 1997, ch. 410, § 8; Laws, 2013, ch. 416, § 8; Laws, 2017, ch. 306, § 1, eff from and after passage (approved Mar. 6, 2017).

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides:

"SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

Cross References — Department of insurance generally, see §§ 83-1-1 et seq.

Insurance companies generally, see §§ 83-5-1 et seq.

Life insurance generally, see §§ 83-7-1 et seq.

Accident and health insurance generally, see §§ 83-9-1 et seq.

Domestic companies generally, see §§ 83-19-1 et seq.

Foreign companies generally, see §§ 83-21-1 et seq.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

Requirements for acquiring control of converted mutual insurance company, see § 83-31-141.

Merger or consolidation of mutual insurance holding companies, see § 83-31-157.

Application of definition of "control" or "controlled" as defined in this section to

Business Transacted with Producer Controlled Insurer Act, see § 83-59-3.

Part 1, Chapter 39, Title 19 of the Mississippi Administrative Code, see CMSR 19-001-39, Rules 39.01 through 39.08.

RESEARCH REFERENCES

ALR.

Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

Am. Jur.

43 Am. Jur. 2d, Insurance § 4.

CJS.

44 C.J.S., Insurance §§ 1-75.

Practice References.

Business Law Monographs, Volume IN1—Business Uses of Life Insurance (Matthew Bender Elite Products).

§ 83-6-2. Subsidiaries which may be organized or acquired; permissible investments.

(1) Any domestic insurer, either by itself or in cooperation with one or more persons, may organize or acquire one or more subsidiaries engaged in the following kinds of business:

(a) Any kind of insurance business authorized by the jurisdiction in which it is incorporated;

(b) Acting as an insurance broker or as an insurance agent for its parent or for any of its parent's insurer subsidiaries;

(c) Investing, reinvesting or trading in securities for its own account, that of its parent, any subsidiary of its parent, or any affiliate or subsidiary;

(d) Management of any investment company subject to or registered pursuant to the Investment Company Act of 1940, as amended, including related sales and services;

(e) Acting as a broker-dealer subject to or registered pursuant to the Securities Exchange Act of 1934, as amended;

(f) Rendering investment advice to governments, government agencies, corporations or other organizations or groups;

(g) Rendering other services related to the operations of an insurance business including, but not limited to, actuarial, loss prevention, safety engineering, data processing, accounting, claims, appraisal and collection services;

(h) Ownership and management of assets which the parent corporation could itself own or manage;

(i) Acting as administrative agent for a governmental instrumentality which is performing an insurance function;

(j) Financing of insurance premiums, agents and other forms of consumer financing;

(k) Any other business activity determined by the commissioner to be reasonably ancillary to an insurance business; or

(*l*) Owning a corporation or corporations engaged or organized to engage exclusively in one or more of the businesses specified in this section.

(2) In addition to investments in common stock, preferred stock, debt obligations and other securities permitted under Chapter 573, Laws of 1992, a domestic insurer may also:

(a) Invest, in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries, amounts which do not exceed the lesser of ten percent (10%) of such insurer's assets or fifty percent (50%) of such insurer's surplus as regards policyholders, provided that after such investments, the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of such investments, investments in domestic or foreign insurance subsidiaries shall be excluded, and there shall be included:

(i) Total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of such subsidiary whether or not represented by the purchase of capital stock or issuance of other securities, and

(ii) All amounts expended in acquiring additional common stock, preferred stock, debt obligations, other securities and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation;

(b) Invest any amount in common stock, preferred stock, debt obligations and other securities of one or more subsidiaries engaged or organized to engage exclusively in the ownership and management of assets authorized as investments for the insurer provided that each such subsidiary agrees to limit its investments in any asset so that such investments will not cause the amount of the total investment of the insurer to exceed any of the investment limitations specified in subsection (2)(a). For the purpose of Chapter 573, Laws of 1992, "the total investment of the insurer" shall include:

(i) Any direct investment by the insurer in an asset, and

(ii) The insurer's proportionate share of any investment in an asset by any subsidiary of the insurer, which shall be calculated by multiplying the amount of the subsidiary's investment by the percentage of the ownership of such subsidiary;

(c) With the approval of the commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more subsidiaries, provided that after such investment the insurer's surplus as regards policyholders will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(3) Investments in common stock, preferred stock, debt obligations or other securities of subsidiaries made pursuant to subsection (1) or (2) above shall not be subject to any of the otherwise applicable restrictions or prohibitions contained in Section 83-19-51, Mississippi Code of 1972.

(4) Whether any investment pursuant to subsection (2) meets the applicable requirements thereof is to be determined before such investment is

made, by calculating the applicable investment limitations as though the investment had already been made, taking into account the then outstanding principal balance on all previous investments in debt obligations, and the value of all previous investments in equity securities as of the day they were made, net of any return of capital invested, not including dividends.

(5) If an insurer ceases to control a subsidiary, it shall dispose of any investment therein made pursuant to this section within three (3) years from the time of the cessation of control or within such further time as the commissioner may prescribe, unless at any time after such investment shall have been made, such investment shall have met the requirements for investment under any other section of Chapter 573, Laws of 1992, and the insurer has notified the commissioner thereof.

HISTORY: Laws, 1992, ch. 573, § 4, eff from and after July 1, 1992.

Editor's Notes — For a complete list of sections affected by Chapter 573, Laws of 1992, see the Statutory Tables volume, Table B, Allocation of Acts, 1992 Session.

Cross References — Stock of subsidiary corporation of insurer not to be valued at amount in excess of net value based upon assets eligible under this section, see § 83-5-117.

Mutual insurance holding company investments, see § 83-31-167.

Federal Aspects — Securities Exchange Act of 1934, see 15 USCS §§ 78a et seq. Investment Company Act of 1940, see 15 USCS §§ 80a-1 et seq.

§ 83-6-3. Insurers required to register; time for registration; data may be required of other insurers.

Every insurer which is authorized to do business in this state and which is a member of an insurance holding company system, except a foreign insurer subject to disclosure requirements and standards adopted by statute or regulation in the jurisdiction of its domicile which are substantially similar to those contained in Sections 83-6-3 through 83-6-19, is required to register with the commissioner. Any insurer which is subject to registration under Sections 83-6-3 through 83-6-19 is required to register within sixty (60) days after July 1, 1974, or fifteen (15) days after it becomes subject to registration, whichever is later, unless the commissioner for good cause shown extends the time for registration, and then within such extended time. The commissioner may require any authorized insurer which is a member of a holding company system which is not subject to registration under Sections 83-6-3 through 83-6-19 to furnish a copy of the registration statement or other information filed by such insurer with the insurance regulatory authority of its domiciliary jurisdiction.

HISTORY: Laws, 1974, ch. 366, § 267, eff from and after July 1, 1974.

RESEARCH REFERENCES

ALR.
Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance §§ 76-80.

§ 83-6-5. Registration statement; filing, form and contents; annual enterprise risk report.

(1) Every insurer subject to registration is required to file a registration statement on a form provided by the commissioner which shall contain current information setting forth:

(a) The capital structure, general financial condition, ownership and management of the insurer and any person controlling the insurer;

(b) The identity of every member of the insurance holding company system;

(c) The following agreements in force, relationships subsisting and transactions currently outstanding between such insurer and its affiliates:

(i) Loans, other investments or purchases, sales or exchanges of securities of the affiliates by the insurer or of the insurer by its affiliates;

(ii) Purchases, sales or exchanges of assets;

(iii) Transactions not in the ordinary course of business;

(iv) Guarantees or undertakings for the benefit of an affiliate which result in an actual contingent exposure of the insurer's assets to liability, other than insurance contracts entered into in the ordinary course of the insurer's business;

(v) All management and service contracts and all cost-sharing arrangements, other than cost allocation arrangements based upon generally accepted accounting principles;

(vi) Reinsurance agreements covering all or substantially all of one or more lines of insurance of the ceding company;

(vii) Dividends and other distributions to shareholders; and

(viii) Consolidated tax allocation agreements.

(d) Any pledge of the insurer's stock, including stock of any subsidiary or controlling affiliate, for a loan made to any member of the insurance holding company system;

(e) If requested by the commissioner, the insurer shall include financial statements of or within an insurance holding company system, including all affiliates. Financial statements may include, but are not limited to, annual audited financial statements filed with the United States Securities and Exchange Commission (SEC) pursuant to the Securities Act of 1933, as amended, or the Securities Exchange Act of 1934, as amended. An insurer required to file financial statements pursuant to this paragraph may satisfy the request by providing the commissioner with the most recently filed parent corporation financial statements that have been filed with the SEC;

(f) Other matters concerning transactions between registered insurers and any affiliates as may be included from time to time in any registration forms adopted or approved by the commissioner;

(g) Statements that the insurer's board of directors oversees corporate governance and internal controls and that the insurer's officers or senior management have approved, implemented, and continue to maintain and monitor corporate governance and internal control procedures.

(2) All registration statements shall contain a summary outlining all items in the current registration statement representing changes from the prior registration statement.

(3) Subject to Section 83-6-25, each registered insurer shall report to the commissioner all dividends and other distributions to shareholders within fifteen (15) business days following the declaration thereof.

(4) Any person within an insurance holding company system subject to registration shall be required to provide complete and accurate information to an insurer, where the information is reasonably necessary to enable the insurer to comply with the provisions of this chapter.

(5) The ultimate controlling person of every insurer subject to registration shall also file an annual enterprise risk report. The report shall, to the best of the ultimate controlling person's knowledge and belief, identify the material risks within the insurance holding company system that could pose enterprise risk to the insurer. The report shall be filed with the lead state commissioner of the insurance holding company system as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

HISTORY: Laws, 1974, ch. 366, § 2(2); Laws, 2013, ch. 416, § 9, eff from and after July 1, 2013.

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Federal Aspects — Securities Act of 1933, see 15 USCS §§ 77a et seq. Securities Exchange Act of 1934, see 15 USCS §§ 78a et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance §§ 76-83, 96.

§ 83-6-7. Registration statement; immaterial information need not be disclosed; items deemed to be immaterial.

No information need be disclosed on the registration statement filed pursuant to Section 83-6-5 if such information is not material for the purposes of Sections 83-6-3 through 83-6-19. Unless the commissioner by rule, regulation or order provides otherwise, sales, purchases, exchanges, loans or extensions of credit or investments involving one-half of one percent (½ of 1%) or less of an insurer's admitted assets as of the thirty-first day of December next preceding are not to be deemed material for purposes of Sections 83-6-3 through 83-6-19.

HISTORY: Laws, 1974, ch. 366, § 2(3), eff from and after July 1, 1974.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance §§ 76-83, 96.

§ 83-6-9. Registration statement; report of material changes or additions on amendment forms.

Each registered insurer is required to keep current the information required to be disclosed in its registration statement by reporting all material changes or additions on amendment forms provided by the commissioner within fifteen (15) days after the end of the month in which it learns of each such change or addition.

HISTORY: Laws, 1974, ch. 366, § 2(4), eff from and after July 1, 1974.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance §§ 76-83, 96.

§ 83-6-11. Termination of registration of insurer no longer member of insurance holding company system; consolidated registration statement or amendment by affiliated insurers.

(1) The commissioner is required to terminate the registration of any insurer which demonstrates that it no longer is a member of an insurance holding company system.

(2) The commissioner may require or allow two (2) or more affiliated insurers subject to registration hereunder to file a consolidated registration statement or consolidated reports amending their consolidated registration statement on their individual registration statements.

HISTORY: Laws, 1974, ch. 366, § 2(5, 6), eff from and after July 1, 1974.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-6-13. Insurer may register on behalf of affiliated insurer, when.

The commissioner may allow an insurer which is authorized to do business in this state and which is part of an insurance holding company system to register on behalf of any affiliated insurer which is required to register under Section 83-6-3 and to file all information and material required to be filed under Sections 83-6-3 through 83-6-19.

HISTORY: Laws, 1974, ch. 366, § 2(7), eff from and after July 7, 1974.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 70.	44 C.J.S., Insurance §§ 76-83, 96.

§ 83-6-15. Exemption of insurer, information or transaction from application of §§ 83-6-3 through 83-6-19.

The provisions of Sections 83-6-3 through 83-6-19 do not apply to any insurer, information or transaction if and to the extent that the commissioner, by rule, regulation or order, exempts the same from the provisions of Sections 83-6-3 through 83-6-19.

HISTORY: Laws, 1974, ch. 366, § 2(8), eff from and after July 1, 1974.

Cross References — Publication by commissioner of rules, regulations and orders, see § 83-6-29.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance §§ 63, 67, 70.	44 C.J.S., Insurance §§ 76-80, 96.

§ 83-6-17. Disclaimer of affiliation; effect of filing; disallowance.

Any person may file with the commissioner a disclaimer of affiliation with any authorized insurer or such a disclaimer may be filed by such insurer or any member of an insurance holding company system. The disclaimer shall fully disclose all material relationships and bases for affiliation between such person and such insurer as well as the basis for disclaiming such affiliation. A disclaimer of affiliation shall be deemed to have been granted unless the commissioner, within thirty (30) days following receipt of a complete disclaimer, notifies the filing party that the disclaimer is disallowed. In the event of disallowance, the disclaiming party may request an administrative hearing, which shall be granted. The disclaiming party is relieved of any duty to register or report under this chapter which may arise out of the insurer's relationship with such person if approval of the disclaimer has been granted by the commissioner, until the commissioner disallows such a disclaimer.

HISTORY: Laws, 1974, ch. 366, § 2(9); Laws, 2013, ch. 416, § 10, eff from and after July 1, 2013.

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:
"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."
Cross References — Rebuttal of presumption of control by showing made under this section, see § 83-6-1(c).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 67, 70.

CJS.
44 C.J.S., Insurance §§ 76-80, 96.

§ 83-6-19. Failure to file registration statement or amendment as violation.

The failure to file a registration statement or any amendment thereto required by Sections 83-6-3 through 83-6-19 within the time specified for such filing is a violation of Sections 83-6-3 through 83-6-19.

HISTORY: Laws, 1974, ch. 366, § 2(10), eff from and after July 1, 1974.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 69, 70.

CJS.
44 C.J.S., Insurance §§ 93, 124, 139-141.

§ 83-6-21. Standards for transactions within holding company system; notice to commissioner of certain intended transactions; action by commissioner against violators; stock company permits; dividends and other distributions.

(1) Transactions within a holding company system to which an insurer subject to registration is a party shall be subject to the following standards:

(a) The terms shall be fair and reasonable;

(b) Agreements for cost sharing services and management shall include such provisions as required by rule and regulation issued by the commissioner;

(c) Charges or fees for services performed shall be reasonable;

(d) Expenses incurred and payment received shall be allocated to the insurer in conformity with customary insurance accounting practices consistently applied;

(e) The books, accounts and records of each party to all such transactions shall be so maintained as to clearly and accurately disclose the nature and details of the transactions including such accounting information as is necessary to support the reasonableness of the charges or fees to the respective parties; and

(f) The insurer's surplus as regards policyholders following any dividends or distributions to shareholder affiliates shall be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs.

(2) The following transactions involving a domestic insurer and any person in its holding company system, including amendments or modifications of affiliate agreements previously filed pursuant to this section, which are subject to any materiality standards contained in paragraphs (a) through (i) of this subsection, shall not be entered into unless the insurer has notified the commissioner in writing of its intention to enter into such transaction at least thirty (30) days prior thereto, or such shorter period as the commissioner may permit, and the commissioner has not disapproved it within such period. The notice for amendments or modifications shall include the reasons for the change and the financial impact on the domestic insurer. Informal notice shall be reported within thirty (30) days after a termination of a previously filed agreement to the commissioner for determination of the type of filing required, if any.

(a) Sales, purchases, exchanges, loans or extension of credit, guarantees or investments provided such transactions are equal to or exceed: (i) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; and (ii) with respect to life insurers, three percent (3%) of the insurer's admitted assets; each as of December 31 next preceding:

(b) Loans or extensions of credit to any person who is not an affiliate, where the insurer makes such loans or extension of credit with the agreement or understanding that the proceeds of such transactions, in whole or in substantial part, are to be used to make loans or extensions of credit to, to purchase assets of or to make investments in, any affiliate of the insurer making such loans or extensions of credit provided such transactions are equal to or exceed: (i) with respect to nonlife insurers, the lesser of three percent (3%) of the insurer's admitted assets or twenty-five percent (25%) of surplus as regards policyholders; and (ii) with respect to life insurers, three percent (3%) of the insurer's admitted assets; each as of December 31 next preceding;

(c) Reinsurance agreements or modifications thereto, including (i) all reinsurance pooling agreements; and (ii) agreements in which the reinsurance premium or a change in the insurer's liabilities equals or exceeds five percent (5%) of the insurer's surplus as regards policyholders, as of December 31 next preceding, including those agreements which may require as consideration the transfer of assets from an insurer to a nonaffiliate, if an agreement or understanding exists between the insurer and nonaffiliate that any portion of such assets will be transferred to one or more affiliates of the insurer;

(d) All management agreements that would place control of the insurer outside of the insurance holding company system;

(e) All service contracts or cost-sharing arrangements wherein the annual aggregate cost to the insurer would equal or exceed the amounts specified in paragraph (a) of this subsection;

(f) All tax allocation agreements;

(g) Guarantees when made by a domestic insurer; provided, however, that a guarantee which is quantifiable as to amount is not subject to the notice requirements of this paragraph unless it exceeds the lesser of one-half of one percent (.5%) of the insurer's admitted assets or ten percent (10%) of surplus as regards policyholders as of December 31 next preceding. Further, all guarantees which are not quantifiable as to amounts are subject to the notice requirements of this paragraph;

(h) Direct or indirect acquisitions or investments in a person that controls the insurer or in an affiliate of the insurer in an amount which, together with its present holdings in such investments, exceeds two and one-half percent (2.5%) of the insurer's surplus as to policyholders. Direct or indirect acquisitions or investments in subsidiaries acquired pursuant to Section 83-6-2, or in nonsubsidiary insurance affiliates that are subject to the provisions of this chapter, are exempt from this requirement; and

(i) Any material transactions, specified by regulation, which the commissioner determines may adversely affect the interests of the insurer's policyholders.

Nothing in this subsection (2) shall be determined to authorize or permit any transactions which, in the case of an insurer not a member of the same insurance holding company system, would be otherwise contrary to law.

(3) A domestic insurer shall not enter into transactions which are part of a plan or series of like transactions with persons within the holding company system if the purpose of those separate transactions is to avoid the statutory threshold amount and avoid the review that would occur otherwise. If the commissioner determines that such separate transactions were entered into over any twelve-month period for such purpose, he may exercise his authority under Section 83-6-35.

(4) The commissioner, in reviewing transactions pursuant to subsection (2) of this section, shall consider whether the transactions comply with the standards set forth in subsection (1) of this section and whether they may adversely affect the interests of policyholders.

(5) The commissioner shall be notified within thirty (30) days of any investment of the domestic insurer in any one (1) corporation if the total investment in such corporation by the insurance holding company system exceeds ten percent (10%) of such corporation's voting securities.

(6) Insurance companies within a holding company system shall not sell or exchange their stock among each other unless the companies have obtained stock company permits before conducting such transactions.

(7) Dividends and other Distributions. No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distribution to its

shareholders until thirty (30) days after the commissioner has received notice of the declaration thereof and has not within that period disapproved the payment, or until the commissioner has approved the payment within the thirty-day period. For purposes of this subsection, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property, whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the lesser of:

(a) Ten percent (10%) of the insurer's surplus as regards policyholders as of the 31st day of December next preceding; or

(b) The net gain from operations of the insurer, if the insurer is a life insurer, or the net income, if the insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the 31st day of December next preceding, but shall not include pro rata distributions of any class of the insurer's own securities.

In determining whether a dividend or distribution is extraordinary, an insurer other than a life insurer may carry forward net income from the previous two (2) calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net income from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years. Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval, and the declaration shall confer no rights upon shareholders until the commissioner has approved the payment of the dividend or distribution, or the commissioner has not disapproved payment within the thirty-day period referred to above.

HISTORY: Laws, 1974, ch. 366, § 3(1); Laws, 1992, ch. 573, § 2; Laws, 1998, ch. 323, § 1; Laws, 2013, ch. 416, § 11; Laws, 2017, ch. 306, § 2, eff from and after passage (approved Mar. 6, 2017).

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides:

"SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 63, 71, 74, 78.

CJS.

44 C.J.S., Insurance §§ 121-123.

§ 83-6-22. Acquisitions involving insurers not otherwise covered.

(1) **Definitions.** The following definitions shall apply for the purposes of this section only:

(a) "Acquisition" means any agreement, arrangement or activity the consummation of which results in a person acquiring directly or indirectly the control of another person, and includes, but is not limited to, the acquisition of voting securities, the acquisition of assets, bulk reinsurance and mergers.

(b) An "involved insurer" includes an insurer which either acquires or is acquired, is affiliated with an acquirer or acquired, or is the result of a merger.

(2) **Scope.**

(a) Except as exempted in paragraph (b) of this subsection, this section applies to any acquisition in which there is a change in control of an insurer authorized to do business in this state;

(b) This section shall not apply to the following:

(i) A purchase of securities solely for investment purposes so long as the securities are not used by voting or otherwise to cause or attempt to cause the substantial lessening of competition in any insurance market in this state. If a purchase of securities results in a presumption of control under Section 83-6-1(c), it is not solely for investment purposes unless the commissioner of the insurer's state of domicile accepts a disclaimer of control or affirmatively finds that control does not exist and the disclaimer action or affirmative finding is communicated by the domiciliary commissioner to the commissioner of this state;

(ii) The acquisition of a person by another person when both persons are neither directly nor through affiliates primarily engaged in the business of insurance, if preacquisition notification is filed with the commissioner in accordance with subsection (3)(a) of this section thirty (30) days prior to the proposed effective date of the acquisition. However, such preacquisition notification is not required for exclusion from this section if the acquisition would otherwise be excluded from this section by any other subparagraph of this paragraph (b);

(iii) The acquisition of already affiliated persons;

(iv) An acquisition if, as an immediate result of the acquisition:

1. In no market would the combined market share of the involved insurers exceed five percent (5%) of the total market;

2. There would be no increase in any market share; or

3. In no market would:

a. The combined market share of the involved insurers exceeds twelve percent (12%) of the total market; and

b. The market share increase by more than two percent (2%) of the total market.

For the purpose of this subsection (2)(b)(iv), a market means direct written insurance premium in this state for a line of business as contained in the annual statement required to be filed by insurers licensed to do business in this state;

(v) An acquisition for which a preacquisition notification would be required pursuant to this section due solely to the resulting effect on the ocean marine insurance line of business;

(vi) An acquisition of an insurer whose domiciliary commissioner affirmatively finds that the insurer is in failing condition; there is a lack of feasible alternative to improving such condition; the public benefits of improving the insurer's condition through the acquisition exceed the public benefits that would arise from not lessening competition; and the findings are communicated by the domiciliary commissioner to the commissioner of this state.

(3) **Preacquisition notification; waiting period.** An acquisition covered by subsection (2) may be subject to an order pursuant to subsection (5) unless the acquiring person files a preacquisition notification and the waiting period has expired. The acquired person may file a preacquisition notification. The commissioner shall give confidential treatment to information submitted under this subsection in the same manner as provided in this chapter.

(a) The preacquisition notification shall be in such form and contain such information as prescribed by the National Association of Insurance Commissioners (NAIC) relating to those markets which, under subsection (2)(b)(iv) of this section, cause the acquisition not to be exempted from the provisions of this section. The commissioner may require such additional material and information as deemed necessary to determine whether the proposed acquisition, if consummated, would violate the competitive standard of subsection (4) of this section. The required information may include an opinion of an economist as to the competitive impact of the acquisition in this state accompanied by a summary of the education and experience of such person indicating his or her ability to render an informed opinion.

(b) The waiting period required shall begin on the date of receipt of the commissioner of a preacquisition notification and shall end on the earlier of the thirtieth day after the date of receipt, or termination of the waiting period by the commissioner. Prior to the end of the waiting period, the commissioner on a one-time basis may require the submission of additional needed information relevant to the proposed acquisition, in which event the waiting period shall end on the earlier of the thirtieth day after receipt of the additional information by the commissioner or termination of the waiting period by the commissioner.

(4) **Competitive standard.**

(a) The commissioner may enter an order under subsection (5)(a) of this section with respect to an acquisition if there is substantial evidence that the effect of the acquisition may be substantially to lessen competition in any line of insurance in this state or tend to create a monopoly or if the insurer fails to file adequate information in compliance with subsection (3) of this section.

(b) In determining whether a proposed acquisition would violate the competitive standard of paragraph (a) of this subsection, the commissioner shall consider the following:

(i) Any acquisition covered under subsection (2) of this section involving two (2) or more insurers competing in the same market is prima facie evidence of violation of the competitive standards.

1. If the market is highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
4%	4% or more
10%	2% or more
15%	1% or more

2. Or, if the market is not highly concentrated and the involved insurers possess the following shares of the market:

Insurer A	Insurer B
5%	5% or more
10%	4% or more
15%	3% or more
19%	1% or more

A highly concentrated market is one in which the share of the four (4) largest insurers is seventy-five percent (75%) or more of the market. Percentages not shown in the tables are interpolated proportionately to the percentages that are shown. If more than two (2) insurers are involved, exceeding the total of the two (2) columns in the table is prima facie evidence of violation of the competitive standard in paragraph (a) of this subsection. For the purpose of this item, the insurer with the largest share of the market shall be deemed to be Insurer A.

(ii) There is a significant trend toward increased concentration when the aggregate market share of any grouping of the largest insurers in the market, from the two (2) largest to the eight (8) largest, has increased by seven percent (7%) or more of the market over a period of time extending from any base year five (5) to ten (10) years prior to the acquisition up to the time of the acquisition. Any acquisition or merger covered under subsection (2) of this section involving two (2) or more insurers competing in the same market is prima facie evidence of violation of the competitive standard in paragraph (a) of this subsection if:

1. There is a significant trend toward increased concentration in the market;

2. One (1) of the insurers involved is one of the insurers in a grouping of large insurers showing the requisite increase in the market share; and

3. Another involved insurer's market is two percent (2%) or more.

(iii) For the purposes of paragraph (b) of this subsection (4):

1. The term "insurer" includes any company or group of companies under common management, ownership or control;

2. The term "market" means the relevant product and geographical markets. In determining the relevant product and geographical markets, the commissioner shall give due consideration to, among other things, the definitions or guidelines, if any, promulgated by the NAIC and to information, if any, submitted by parties to the acquisition. In the absence of sufficient information to the contrary, the relevant product market is assumed to be the direct written insurance premium for a line of business, such line being that used in the annual statement required to be filed by insurers doing business in this state, and the relevant geographical market is assumed to be this state;

3. The burden of showing prima facie evidence of violation of the competitive standard rests upon the commissioner.

(iv) Even though an acquisition is not prima facie violative of the competitive standard under paragraph (b)(i) and (ii) of this subsection (4), the commissioner may establish the requisite anticompetitive effect based upon other substantial evidence. Even though an acquisition is prima facie violative of the competitive standard under paragraph (b)(i) and (ii) of this subsection (4), a party may establish the absence of the requisite anticompetitive effect based upon other substantial evidence. Relevant factors in making a determination under this subparagraph include, but are not limited to, the following: market shares, volatility of ranking of market leaders, number of competitors, concentration, trend of concentration in the industry, and ease of entry and exit into the market.

(c) An order may not be entered under subsection (5)(a) of this section if:

(i) The acquisition will yield substantial economies of scale or economies in resource utilization that cannot be feasibly achieved in any other way, and the public benefits which would arise from such economies exceed the public benefits which would arise from not lessening competition; or

(ii) The acquisition will substantially increase the availability of insurance, and the public benefits of the increase exceed the public benefits which would arise from not lessening competition.

(5) **Orders and penalties.**

(a)(i) If an acquisition violates the standards of this section, the commissioner may enter an order:

1. Requiring an involved insurer to cease and desist from doing business in this state with respect to the line or lines of insurance involved in the violation; or

2. Denying the application of an acquired or acquiring insurer for a license to do business in this state.

(ii) Such an order shall not be entered unless there is a hearing:

1. Notice of the hearing is issued prior to the end of the waiting period and not less than fifteen (15) days prior to the hearing; and

2. The hearing is concluded and the order is issued no later than sixty (60) days after the date of the filing of the preacquisition notification with the commissioner.

Every order shall be accompanied by a written decision of the commissioner setting forth findings of fact and conclusions of law.

(iii) An order pursuant to this paragraph shall not apply if the acquisition is not consummated.

(b) Any person who violates a cease and desist order of the commissioner under paragraph (a) of this subsection and while the order is in effect may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to one or more of the following:

(i) A monetary penalty of not more than Ten Thousand Dollars ($10,000.00) for every day of violation; or

(ii) Suspension or revocation of the person's license.

(iii) Any insurer or other person who fails to make any filing required by this section, and who also fails to demonstrate a good faith effort to comply with any filing requirement, shall be subject to a fine of not more than Fifty Thousand Dollars ($50,000.00).

(6) **Inapplicable provisions.** Section 83-6-33(2) and (3) and Section 83-6-39 do not apply to acquisitions covered under this section.

HISTORY: Laws, 2017, ch. 306, § 4, eff from and after passage (approved Mar. 6, 2017).

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-6-23. Factors to be considered in determining reasonableness of insurer's surplus.

For purposes of this chapter, in determining whether an insurer's surplus as regards policyholders is reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs, the following factors, among others, are to be considered:

(a) The size of the insurer as measured by its assets, capital and surplus, reserves, premium writings, insurance in force and other appropriate criteria;

(b) The extent to which the insurer's business is diversified among the several lines of insurance;

(c) The number and size of risks insured in each line of business;

(d) The extent of the geographical dispersion of the insurer's insured risks;

(e) The nature and extent of the insurer's reinsurance program;

(f) The quality, diversification and liquidity of the insurer's investment portfolio;

(g) The recent past and projected future trend in the size of the insurer's surplus as regards policyholders;

(h) The surplus as regards policyholders maintained by other comparable insurers;

(i) The adequacy of the insurer's reserves; and

(j) The quality and liquidity of investments in affiliates. The commissioner may treat any such investment as a disallowed asset for purposes of determining the adequacy of surplus as regards policyholders whenever in his judgment such investment so warrants.

HISTORY: Laws, 1974, ch. 366, § 3(2), eff from and after July 1, 1974.

Cross References — Capital requirement for various classes of domestic companies, see § 83-19-31.

Penalty for failure to report impairment of surplus of domestic company, see § 83-19-75.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance §§ 71, 72.	44 C.J.S., Insurance §§ 121-123.

§ 83-6-24. Filing of statement by person making offer, request, etc.; contents of statement; approval by commissioner; exceptions; violations of section; jurisdiction of courts.

(1)(a) No person other than the issuer shall make a tender offer for or a request or invitation for tenders of, or enter into any agreement to exchange securities, or seek to acquire, or acquire, in the open market or otherwise, any voting security of a domestic insurer if, after the consummation thereof, such person would, directly or indirectly (or by conversion or by exercise of any right to acquire) be in control of such insurer, and no person shall enter into an agreement to merge with or otherwise to acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time any such offer, request, or invitation is made or any such agreement is entered into, or prior to the acquisition of such securities if no offer or agreement is involved, such person has filed with the commissioner and has sent to such insurer, a statement containing the information required by this section and such offer, request, invitation, agreement or acquisition has been approved by the commissioner in the manner hereinafter prescribed.

(b) For the purposes of this section, "a domestic insurer" shall include any person controlling a domestic insurer unless such person as determined by the commissioner is either directly or through its affiliates primarily engaged in business other than the business of insurance. However, such person shall file a preacquisition notification with the commissioner containing the information set forth in this section thirty (30) days prior to the proposed effective date of the acquisition. For the purposes of this section, "person" shall not include any securities broker holding, in the usual and customary brokers function, less than twenty percent (20%) of the voting securities of an insurance company or of any person which controls an insurance company.

(c) For purposes of this section, any controlling person of a domestic insurer seeking to divest its controlling interest in the domestic insurer, in any manner, shall file with the commissioner, with a copy to the insurer, confidential notice of its proposed divestiture at least thirty (30) days prior to the cessation of control. The commissioner shall determine those instances in which the party(ies) seeking to divest or to acquire a controlling interest in an insurer will be required to file for and obtain approval of the transaction. The information shall remain confidential until the conclusion of the transaction unless the commissioner, in his discretion, determines that confidential treatment will interfere with enforcement of this section. If the statement referred to in paragraph (b) of this subsection is otherwise filed, this paragraph shall not apply.

(d) With respect to a transaction subject to this section, the acquiring person must also file a preacquisition notification with the commissioner, which shall contain the information set forth in Section 83-6-22(3)(a). A failure to file the notification may be subject to penalties specified in Section 83-6-22(5).

(2) The statement to be filed with the commissioner hereunder shall be made under oath or affirmation and shall contain the following information:

(a) The name and address of each person by whom or on whose behalf the merger or other acquisition of control referred to in subsection (1) is to be effected (hereinafter called "acquiring party"), and

(i) If such person is an individual, his principal occupation and all offices and positions held during the past five (5) years, and any conviction of crimes other than minor traffic violations during the past ten (10) years;

(ii) If such person is not an individual, a report of the nature of its business operations during the past five (5) years or for such lesser period as such person and any predecessors thereof shall have been in existence; an informative description of the business intended to be done by such person and such person's subsidiaries; and a list of all individuals who are or who have been selected to become directors or executive officers of such person, or who perform or will perform functions appropriate to such positions. Such list shall include for each such individual the information required by subparagraph (i).

(b) The source, nature and amount of consideration used or to be used in effecting the merger or other acquisition of control, a description of any transaction wherein funds were or are to be obtained for any such purpose (including any pledge of the insurer's stock, or the stock of any of its subsidiaries or controlling affiliates), and the identity of persons furnishing such consideration, provided, however, that where a source of such consideration is a loan made in the lender's ordinary course of business, the identity of the lender shall remain confidential, if the person filing such statement so requests.

(c) Fully audited financial information as to the earnings and financial condition of each acquiring party for the preceding five (5) fiscal years of each such acquiring party (or for such lesser period as such acquiring party and any predecessors thereof shall have been in existence), and similar unaudited information as of a date not earlier than ninety (90) days prior to the filing of the statement.

(d) Any plans or proposals which each acquiring party may have to liquidate such insurer, to sell its assets or merge or consolidate it with any person, or to make any other material change in its business or corporate structure or management.

(e) The number of shares of any security referred to in subsection (1) which each acquiring party proposes to acquire, and the terms of the offer, request, invitation, agreement or acquisition referred to in subsection (1), and a statement as to the method by which the fairness of the proposal was determined.

(f) The amount of each class of any security referred to in subsection (1) which is beneficially owned or concerning which there is a right to acquire beneficial ownership by each acquiring party.

(g) A full description of any contracts, arrangements or understandings with respect to any security referred to in subsection (1) in which any acquiring party is involved, including but not limited to, transfer of any of the securities, joint ventures, loan or option arrangements, puts or calls, guarantees of loans, guarantees against loss or guarantees of profits, division of losses or profits or the giving or withholding of proxies. Such description shall identify the persons with whom such contracts, arrangements or understandings have been entered into.

(h) A description of the purchase of any security referred to in subsection (1) during the twelve (12) calendar months preceding the filing of the statement, by any acquiring party, including the dates of purchase, names of the purchasers and consideration paid or agreed to be paid therefor.

(i) A description of any recommendations to purchase any security referred to in subsection (1) made during the twelve (12) calendar months preceding the filing of the statement, by any acquiring party, or by anyone based upon interviews or at the suggestion of such acquiring party.

(j) Copies of all tender offers for, requests, or invitations for tenders of, exchange offers for and agreements to acquire or exchange any securities referred to in subsection (1) and (if distributed) of additional soliciting material relating thereto.

(k) The terms of any agreement, contract or understanding made with or proposed to be made with any broker-dealer as to solicitation of securities referred to in subsection (1) for tender, and the amount of any fees, commissions or other compensation to be paid to broker-dealers with regard thereto.

(*l*) An agreement by the person required to file the statement referred to in subsection (1) that it will provide the annual report, specified in Section 83-6-5(5), for so long as control exists.

(m) An acknowledgment by the person required to file the statement referred to in subsection (1) that the person and all subsidiaries within its control in the insurance holding company system will provide information to the commissioner upon request as necessary to evaluate enterprise risk to the insurer.

(n) Such additional information as the commissioner may by rule or regulation prescribe as necessary or appropriate for the protection of policyholders of the insurer or in the public interest.

If the person required to file the statement referred to in subsection (1) is a partnership, limited partnership, syndicate or other group, the commissioner may require that the information called for by paragraphs (a) through (n) shall be given with respect to each partner of such partnership or limited partnership, each member of such syndicate or group and each person who controls such partner or member. If any such partner, member or person is a corporation, or the person required to file the statement referred to in subsection (1) is a corporation, the commissioner may require that the information called for by paragraphs (a) through (n) shall be given with respect to such corporation, each officer and director of such corporation and each person who is directly or indirectly the beneficial owner of more than ten percent (10%) of the outstanding voting securities of such corporation.

If any material change occurs in the facts set forth in the statement filed with the commissioner and sent to such insurer pursuant to this section, an amendment setting forth such change, together with copies of all documents and other material relevant to such change, shall be filed with the commissioner and sent to such insurer within two (2) business days after the person learns of such change.

(3) If any offer, request, invitation, agreement or acquisition referred to in subsection (1) is proposed to be made by means of a registration statement under the Securities Act of 1933 or in circumstances requiring the disclosure of similar information under the Securities Exchange Act of 1934, or under a state law requiring similar registration or disclosure, the person required to file the statement referred to in subsection (1) may utilize such documents in furnishing the information called for by that statement.

(4)(a) The commissioner shall approve any merger or other acquisition of control referred to in subsection (1) unless, after a public hearing thereon, he finds that:

(i) After the change of control, the domestic insurer referred to in subsection (1) would not be able to satisfy the requirements for the issuance of a license to write the line or lines of insurance for which it is presently licensed;

(ii) The effect of the merger or other acquisition of control would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein;

(iii) The financial condition of any acquiring party is such as might jeopardize the financial stability of the insurer, or prejudice the interest of its policyholders;

(iv) The plans or proposals which the acquiring party has to liquidate the insurer, sell its assets or consolidate or merge it with any person, or to make any other material change in its business or corporate structure or management, are unfair and unreasonable to policyholders of the insurer and not in the public interest;

(v) The competence, experience and integrity of those persons who would control the operation of the insurer are such that it would not be in the interest of policyholders of the insurer and of the public to permit the merger or other acquisition of control; or

(vi) The acquisition is likely to be hazardous or prejudicial to the insurance buying public.

(b) The public hearing referred to in paragraph (a) of this subsection shall be commenced not less than thirty (30) days after the statement required by subsection (1) is filed, and at least twenty (20) days' notice thereof shall be given by the commissioner to the person filing the statement. Not less than seven (7) days' notice of such public hearing shall be given by the person filing the statement to the insurer and to such other persons as may be designated by the commissioner. The commissioner shall make a determination within thirty (30) days after the conclusion of such hearing. At such hearing, the person filing the statement, the insurer, any person to whom notice of hearing was sent, and any other person whose interest may be affected thereby shall have the right to present evidence, examine and cross-examine witnesses, and offer oral and written arguments and in connection therewith shall be entitled to conduct discovery proceedings. All discovery proceedings shall be concluded not later than three (3) days prior to the commencement of the public hearing.

(c) The commissioner may retain at the acquiring person's expense any attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed acquisition of control.

(d) If the proposed acquisition of control will require the approval of more than one (1) commissioner, the public hearing referred to in paragraph (a) of subsection (4) may be held on a consolidated basis upon request of the person filing the statement referred to in subsection (1) of this section. Such person shall file the statement referred to in subsection (1) with the National Association of Insurance Commissioners (NAIC) within five (5) days of making the request for a public hearing. A commissioner may opt out of a consolidated hearing, and shall provide notice to the applicant of the opt out within ten (10) days of the receipt of the statement referred to in subsection (1). A hearing conducted on a consolidated basis shall be public and shall be held within the United States before the commissioners of the states in which the insurers are domiciled. Such commissioners shall hear and receive evidence. A commissioner may attend such hearing, in person or by telecommunication.

(e) In connection with a change of control of a domestic insurer, any determination by the commissioner that the person acquiring control of the insurer shall be required to maintain or restore the capital of the insurer to the level required by the laws and regulations of this state shall be made not later than sixty (60) days after the date of notification of the change in control submitted pursuant to Section 83-6-24(1).

(5) The provisions of this section shall not apply to any offer, request, invitation, agreement or acquisition which the commissioner by order shall exempt therefrom as (i) not having been made or entered into for the purpose and not having the effect of changing or influencing the control of a domestic insurer, or (ii) as otherwise not comprehended within the purposes of this section.

(6) The following shall be violations of this section:

(a) The failure to file any statement, amendment or other material required to be filed pursuant to subsection (1) or (2); or

(b) The effectuation or any attempt to effectuate an acquisition of control of, or merger with, a domestic insurer unless the commissioner has given his approval thereto.

(7) The courts of this state are hereby vested with jurisdiction over every person not resident, domiciled or authorized to do business in this state who files a statement with the commissioner under this section, and overall actions involving such person arising out of violations of this section, and each such person shall be deemed to have performed acts equivalent to and constituting an appointment by such a person of the commissioner to be his true and lawful attorney upon whom may be served all lawful process in any action, suit or proceeding arising out of violations of this section. Copies of all such lawful process shall be served on the commissioner and transmitted by registered or certified mail by the commissioner to such person at his last-known address.

HISTORY: Laws, 1992, ch. 573, § 5; Laws, 1997, ch. 410, § 9; Laws, 2013, ch. 416, § 12; Laws, 2017, ch. 306, § 3, eff from and after passage (approved Mar. 6, 2017).

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides:

"SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

Cross References — Domestic mutual insurance company merger with foreign mutual insurance company, see § 83-31-47.

Federal Aspects — The Securities Act of 1933 is codified as 15 USCS §§ 77a et seq. The Securities Exchange Act of 1934 is codified as 15 USCS §§ 78a et seq.

§ 83-6-25. Restriction on payment of extraordinary dividends or making extraordinary distributions; notice to commissioner.

(1) No domestic insurer shall pay any extraordinary dividend or make any other extraordinary distributions to its shareholders without first making a

written request and receiving written approval for such payment from the commissioner or unless, within the forty-five (45) days after the commissioner has received such written request, the commissioner has not disapproved such payment.

(2) For purposes of this section, an extraordinary dividend or distribution includes any dividend or distribution of cash or other property whose fair market value together with that of other dividends or distributions made within the preceding twelve (12) months exceeds the lesser of: (a) ten percent (10%) of such insurer's surplus as regards policyholders as of the thirty-first day of December next preceding; or (b) the net gain from operations of such insurer, if such insurer is a life insurer, or the net income, if such insurer is not a life insurer, not including realized capital gains, for the twelve-month period ending the thirty-first day of December next preceding, but shall not include pro rata distributions of any class of the insurer's own securities. In determining whether a dividend or distribution is extraordinary, an insurer may carry forward net gain from operations, if such insurer is a life insurer, or net income, if such insurer is not a life insurer, from the previous two (2) calendar years that has not already been paid out as dividends. This carry-forward shall be computed by taking the net gain from operations or the net income, as the case may be, from the second and third preceding calendar years, not including realized capital gains, less dividends paid in the second and immediate preceding calendar years.

(3) Notwithstanding any other provision of law, an insurer may declare an extraordinary dividend or distribution which is conditional upon the commissioner's approval thereof, and such a declaration shall confer no rights upon shareholders until the commissioner has approved the payment of such a dividend or distribution or the commissioner has not disapproved such payment within forty-five (45) days after he has received notice of the declaration.

HISTORY: Laws, 1974, ch. 366, § 3(3); Laws, 1992, ch. 573, § 3; Laws, 2001, ch. 377, § 1, eff from and after July 1, 2001.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 63, 71.

CJS.
44 C.J.S., Insurance §§ 121-123.

§ 83-6-26. Management of domestic insurers subject to registration.

(1) Notwithstanding the control of a domestic insurer by any person, the officers and directors of the insurer shall not thereby be relieved of any obligation or liability to which they would otherwise be subject by law, and the insurer shall be managed so as to assure its separate operating identity consistent with this section.

(2) Nothing in this section shall preclude a domestic insurer from having or sharing a common management or cooperative or joint use of personnel,

property or services with one or more other persons under arrangements meeting the standards of Section 83-6-21.

(3) Not less than one-third (⅓) of the directors of a domestic insurer, and not less than one-third (⅓) of the members of each committee of the board of directors of any domestic insurer shall be persons who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or entity. At least one (1) such person must be included in any quorum for the transaction of business at any meeting of the board of directors or any committee thereof.

(4) The board of directors of a domestic insurer shall establish one or more committees comprised solely of directors who are not officers or employees of the insurer or of any entity controlling, controlled by, or under common control with the insurer and who are not beneficial owners of a controlling interest in the voting stock of the insurer or any such entity. The committee or committees shall have responsibility for nominating candidates for director for election by shareholders or policyholders, evaluating the performance of officers deemed to be principal officers of the insurer and recommending to the board of directors the selection and compensation of the principal officers.

(5) The provisions of subsections (3) and (4) shall not apply to a domestic insurer if the person controlling the insurer, such as an insurer, a mutual insurance holding company, or a publicly held corporation, has a board of directors and committees thereof that meet the requirements of subsections (3) and (4) with respect to such controlling entity.

(6) An insurer may make application to the commissioner for a waiver from the requirements of this section, if the insurer's annual direct written and assumed premium, excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, is less than Three Hundred Million Dollars ($300,000,000.00). An insurer may also make application to the commissioner for a waiver from the requirements of this section based upon unique circumstances. The commissioner may consider various factors including, but not limited to, the type of business entity, volume of business written, availability of qualified board members, or the ownership or organizational structure of the entity.

HISTORY: Laws, 2013, ch. 416, § 13, eff from and after July 1, 2013.

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:
"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

§ 83-6-27. Financial examination of registered insurer or affiliate.

(1) **Power of commissioner.** Subject to the limitation contained in this section and in addition to the powers which the commissioner has under Sections 83-5-201 through 83-5-217 relating to the examination of insurers,

the commissioner shall have the power to examine any insurer registered under Section 83-6-3 and its affiliates to ascertain the financial condition of the insurer, including the enterprise risk to the insurer by the ultimate controlling party, or by any entity or combination of entities within the insurance holding company system, or by the insurance holding company system on a consolidated basis.

(2) **Access to books and records.**

(a) The commissioner may order any insurer registered under Section 83-6-3 to produce such records, books, or other information in the possession of the insurer or its affiliates as are reasonably necessary to determine compliance with this chapter.

(b) To determine compliance with this chapter, the commissioner may order any insurer registered under Section 83-6-3 to produce information not in the possession of the insurer if the insurer can obtain access to such information pursuant to contractual relationships, statutory obligations, or other method. In the event the insurer cannot obtain the information requested by the commissioner, the insurer shall provide the commissioner a detailed explanation of the reason that the insurer cannot obtain the information and the identity of the holder of information. Whenever it appears to the commissioner that the detailed explanation is without merit, the commissioner may require, after notice and hearing, the insurer to pay a penalty of One Hundred Dollars ($100.00) for each day's delay, or may suspend or revoke the insurer's license.

(3) **Use of consultants.** The commissioner may retain at the registered insurer's expense such attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff which are reasonably necessary to assist in the conduct of the examination under subsection (1) of this section. Any persons so retained are under the direction and control of the commissioner and shall act in a purely advisory capacity.

(4) **Expenses.** Each registered insurer producing for examination records, books and papers pursuant to subsection (1) of this section shall be liable for and shall pay the expense of the examination in accordance with Section 83-5-213.

(5) **Compelling production.** In the event the insurer fails to comply with an order, the commissioner shall have the power to examine the affiliates to obtain the information. The commissioner shall also have the power to issue subpoenas, to administer oaths, and to examine under oath any person for purposes of determining compliance with this section. Upon the failure or refusal of any person to obey a subpoena, the commissioner may petition a court of competent jurisdiction, and upon proper showing, the court may enter an order compelling the witness to appear and testify or produce documentary evidence. Failure to obey the court order shall be punishable as contempt of court. Every person shall be obliged to attend as a witness at the place specified in the subpoena, when subpoenaed, anywhere within the state. He or she shall be entitled to the same fees and mileage, if claimed, as a witness in Section 25-7-47, which fees, mileage, and actual expense, if any, necessarily incurred in

securing the attendance of witnesses, and their testimony, shall be itemized and charged against, and be paid by, the company being examined.

HISTORY: Laws, 1974, ch. 366, § 4; Laws, 2001, ch. 379, § 1; Laws, 2013, ch. 416, § 14; Laws, 2017, ch. 306, § 5, eff from and after passage (approved Mar. 6, 2017).

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in subsection (4) by inserting the word "the" following "expense of." The Joint Committee ratified the correction at the August 15, 2017, meeting of the Committee.

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides:

"SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

Cross References — Examination of foreign insurance companies generally, see §§ 83-1-23, 83-1-27.

Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

Application of this section to a financial examination of home warranty associations, see § 83-57-31.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 63, 71.

CJS.
44 C.J.S., Insurance §§ 121-123.

§ 83-6-29. Confidential treatment of information, materials or documents obtained or disclosed during certain examinations.

(1) Documents, materials or other information in the possession or control of the Department of Insurance that are obtained by or disclosed to the commissioner or any other person during an examination or investigation made pursuant to Section 83-6-27 and all information reported pursuant to Sections 83-6-24(2)(*l*) and (m), 83-6-3, 83-6-5 and 83-6-21 shall be confidential by law and privileged, shall not be subject to the Mississippi Public Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer to which it pertains unless the commissioner, after giving the insurer and its affiliates who would be affected thereby notice and

opportunity to be heard, determines that the interest of policyholders, shareholders or the public will be served by the publication thereof, in which event the commissioner may publish all or any part in such manner as may be deemed appropriate.

(2) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to this section shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the commissioner's duties, the commissioner:

(a) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection (1) of this section, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners (NAIC) and its affiliates and subsidiaries, and with state, federal and international law enforcement authorities, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the document, material or other information, and has verified in writing the legal authority to maintain confidentiality.

(b) Notwithstanding paragraph (a) of this subsection, the commissioner may only share confidential and privileged documents, material or information reported pursuant to Section 83-6-5(5) with commissioners of states having statutes or regulations substantially similar to subsection (1) of this section and who have agreed in writing not to disclose such information.

(c) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information from the NAIC and its affiliates and subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information.

(d) Shall enter into written agreements with the NAIC governing sharing and use of information provided pursuant to this section consistent with this subsection that shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC and its affiliates and subsidiaries pursuant to this section, including procedures and protocols for sharing by the NAIC with other state, federal or international regulators;

(ii) Specify that ownership of information shared with the NAIC and its affiliates and subsidiaries pursuant to this section remains with the commissioner and the NAIC's use of the information is subject to the direction of the commissioner;

(iii) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC pursuant to this section is subject to a request or subpoena to the NAIC for disclosure or production; and

(iv) Require the NAIC and its affiliates and subsidiaries to consent to intervention by an insurer in any judicial or administrative action in which the NAIC and its affiliates and subsidiaries may be required to disclose confidential information about the insurer shared with the NAIC and its affiliates and subsidiaries pursuant to this section.

(4) The sharing of information by the commissioner pursuant to this section shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this section.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in subsection (3) of this section.

(6) Documents, materials or other information in the possession or control of the NAIC pursuant to this section shall be confidential by law and privileged, shall not be subject to the Mississippi Public Records Act, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

HISTORY: Laws, 1974, ch. 366, § 5; Laws, 2013, ch. 416, § 15, eff from and after July 1, 2014.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation deleted "Sections" preceding "83-6-3" in the first sentence of (1). The Joint Committee ratified the correction at its August 10, 2022, meeting.

Editor's Notes — Laws of 2013, ch. 416, § 16, provides:

"SECTION 16. This act shall take effect and be in force from and after July 1, 2014, except for the provisions contained in Sections 3 through 14, which shall take effect and be in force from and after July 1, 2013."

Cross References — Mississippi Public Records Act, see § 25-61-1 et seq.

RESEARCH REFERENCES

Am. Jur.

20 Am. Jur. Pl & Pr Forms (Rev), Privacy, Form 97 (complaint, petition, or declaration-against insurance company-unauthorized transmittal of medical information furnished to insurance company).

§ 83-6-31. Rules, regulations and orders.

The commissioner may, upon notice and opportunity for all interested persons to be heard, promulgate and publish rules, regulations and orders which are necessary to the accomplishment of the provisions of this chapter.

HISTORY: Laws, 1974, ch. 366, § 6, eff from and after July 1, 1974.

§ 83-6-33. Enjoinder of violations; enjoinder of voting of certain securities at shareholder's meeting; sequester of certain voting securities.

(1) Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed or is about to commit a violation of this chapter or of any rule, regulation or order issued by the commissioner hereunder, the commissioner may apply to chancery court for the county in which the principal office of the insurer is located, or if such insurer has no office in this state, then to the Chancery Court of Hinds County for an order enjoining such insurer or such director, officer, employee or agent thereof from violating or continuing to violate this chapter or any such rule, regulation or order, and for such other equitable relief as the nature of the case and the interests of the insurer's policyholders, creditors and shareholders or the public may require.

(2) No security that is the subject of any agreement or arrangement regarding acquisition, or that is acquired or to be acquired, in contravention of the provisions of this chapter or of any rule, regulation or order issued by the commissioner hereunder may be voted at any shareholder's meeting or may be counted for quorum purposes, and any action of shareholders requiring the affirmative vote of a percentage of shares may be taken as though such securities were not issued and outstanding; but no action taken at any such meeting shall be invalidated by the voting of such securities unless the action would materially affect control of the insurer or unless the courts of this state have so ordered. If an insurer or the commissioner has reason to believe that any security of the insurer has been or is about to be acquired in contravention of the provisions of this chapter or of any rule, regulation or order issued by the commissioner hereunder, the insurer or the commissioner may apply to the Chancery Court of Hinds County to enjoin any offer, request, invitation, agreement or acquisition made in contravention of any rule, regulation or order issued by the commissioner thereunder to enjoin the voting of any security so acquired, to void any vote of such security already cast at any meeting of shareholders and for such other equitable relief as the nature of the case and the interest of the insurer's policyholders, creditors and shareholders or the public may require.

(3) In any case where a person has acquired or is proposing to acquire any voting securities in violation of this chapter or any rule, regulation or order issued by the commissioner hereunder, the Chancery Court of Hinds County, on the notice as the court requires, upon the application of the insurer or the commissioner, may seize or sequester any voting securities of the insurer owned directly or indirectly by the person and issue the order with respect thereto as may be appropriate to effectuate the provisions of this chapter. For the purposes of this section, the situs of the ownership of the securities of domestic insurers shall be in this state.

HISTORY: Laws, 1974, ch. 366, § 7; Laws, 1994, ch. 467, § 1, eff from and after July 1, 1994.

Cross References — Injunctions generally, see §§ 11-13-1 et seq.

Applicability of this section to acquisitions involving insurers covered under § 83-6-22, see § 83-6-22.

§ 83-6-35. Willful violations; criminal proceedings; punishment.

Whenever it appears to the commissioner that any insurer or any director, officer, employee or agent thereof has committed a willful violation of this chapter, the commissioner may cause criminal proceedings to be instituted in the court having criminal jurisdiction for the county in which the principal office of the insurer is located, or if such insurer has no such office in the state, then in the Circuit Court for the First Judicial District of Hinds County against such insurer or the responsible director, officer, employee or agent thereof. Any insurer which willfully violates this chapter may be fined not more than Five Hundred Dollars ($500.00). Any individual who willfully violates this chapter upon conviction may be fined not more than Five Hundred Dollars ($500.00), or if such willful violation involves the deliberate perpetration of a fraud, may be imprisoned in the state penitentiary for not more than two (2) years, or both.

HISTORY: Laws, 1974, ch. 366, § 8, eff from and after July 1, 1974.

Cross References — Authority for commissioner to proceed against domestic insurer entering into series of transactions to avoid statutory threshold amount and review, see § 83-6-21.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance §§ 69, 74, 78.	44 C.J.S., Insurance §§ 124, 139-141.

§ 83-6-37. When commissioner may take possession and conduct business of domestic insurer.

Whenever it appears to the commissioner that any person has committed a violation of this chapter which so impairs the financial condition of a domestic insurer as to threaten insolvency or make the further transaction of business by it hazardous to its policyholders, creditors, shareholders or the public, the commissioner may proceed as provided in Sections 83-23-1, 83-23-3, 83-23-5 and 83-23-7 to take possession of the property of such domestic insurer and to conduct the business thereof.

HISTORY: Laws, 1974, ch. 366, § 9, eff from and after July 1, 1974.

JUDICIAL DECISIONS

1. In general.

Since under statutes conferring authority on insurance commissioner to act make the interest of the policyholders paramount, immediate action is justified when the policyholder's interest is endangered, and ex parte orders suspending an insurance company's certificate, temporary restraining orders, and temporary appointments ordered without notice are acceptable. State Sec. Life Ins. Co. v. State, 498 So. 2d 825, 1986 Miss. LEXIS 2840 (Miss. 1986).

On complaint filed by the insurance commission, following examination of an insurance company, alleging the insurance company was insolvent and its condition such as to render further business hazardous to the public and to its policyholders, chancellor did not abuse his discretion in granting a temporary restraining order prohibiting the insurance company from further business and appointing the insurance commissioner as its temporary receiver, and in compelling the insurance company and its affiliates to turn over to the insurance commissioner all documents and other records which were requested by the insurance commissioner in writing for the purpose of determining the financial condition and the legality of the conduct of the insurance company and its affiliates. State Sec. Life Ins. Co. v. State, 498 So. 2d 825, 1986 Miss. LEXIS 2840 (Miss. 1986).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 63, 67, 69, 74, 78.

CJS.

44 C.J.S., Insurance §§ 124, 139-141, 197.

§ 83-6-38. Amounts recoverable by receiver upon liquidation or rehabilitation of insurer; limitations; deficiencies due to insolvent debtors.

(1) If an order for liquidation or rehabilitation of a domestic insurer has been entered, the receiver appointed under such order shall have a right to recover on behalf of the insurer, (i) from any parent corporation or holding company or person or affiliate of the insurer, the amount of distributions (other than distributions of shares of the same class of stock) paid by the insurer on its capital stock, or (ii) any payment in the form of a bonus, termination settlement or extraordinary lump sum salary adjustment made by the insurer or its subsidiary(s) to a director, officer or employee, where the distribution or payment pursuant to (i) or (ii) is made at any time during the one (1) year preceding the petition for liquidation, conservation or rehabilitation, as the case may be, subject to the limitations of subsections (2), (3) and (4) of this section.

(2) No such distribution shall be recoverable if the parent or affiliate shows that when paid such distribution was lawful and reasonable, and that the insurer did not know and could not reasonably have known that such distribution might adversely affect the ability of the insurer to fulfill its contractual obligations.

(3) Any person who was a parent corporation or holding company or a person who otherwise controlled the insurer or affiliate at the time such distributions were paid shall be liable up to the amount of distributions or

payments which the person received under subsection (1). Any person who otherwise controlled the insurer at the time such distributions were declared shall be liable up to the amount of distributions he would have received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(4) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the impaired or insolvent insurer to pay the contractual obligations of the impaired or insolvent insurer and to reimburse any guaranty funds.

(5) To the extent that any person liable under subsection (3) of this section is insolvent or otherwise fails to pay claims due from it pursuant to such paragraph, its parent corporation or holding company or person who otherwise controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from such parent corporation or holding company or person who otherwise controlled it.

HISTORY: Laws, 1992, ch. 573, § 6, eff from and after July 1, 1992.

§ 83-6-39. Suspension, revocation or refusal to renew license or certificate of authority.

Whenever it appears to the commissioner that any person has committed a violation of this chapter which makes the continued operation of an insurer contrary to the interests of policyholders or the public, the commissioner may, after giving notice and an opportunity to be heard, determine to suspend, revoke or refuse to renew such insurer's license or certificates of authority to do business in this state or both for such period as he finds is required for the protection of policyholders or the public. Any such determination shall be accompanied by specific findings of fact and conclusions of law.

HISTORY: Laws, 1974, ch. 366, § 10, eff from and after July 1, 1974.

Cross References — Additional authority to suspend or revoke certificate of authority, see § 83-1-29.

Applicability of this section to acquisitions involving insurers covered under § 83-6-22, see § 83-6-22.

Application of hearing procedures in this section to determination of violation of Managing General Agents Act, see § 83-18-111.

Application of this section to determination of violations of Reinsurance Intermediary Act, see § 83-19-221.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 67, 68, 69.

1A Am. Jur. Pl & Pr Forms (Rev), Administrative Law, Form 341.2 (complaint, petition, or declaration – by license holder – against administrative agency-to enjoin further proceedings to suspend or revoke license – attempt to suspend or revoke license on grounds not listed in statute authorizing suspension or revocation of license.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commis-

sioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance §§ 105-115, 124, 139-141.

§ 83-6-41. Appeals to chancery court; petition for writ in nature of mandamus or peremptory mandamus.

(1) Any person aggrieved by any act, determination, rule, regulation or order or any other action of the commissioner pursuant to this chapter may appeal to the Chancery Court of the First Judicial District of Hinds County.

(2) The filing of an appeal pursuant to this section shall stay the application of any such rule, regulation, order or other action of the commissioner to the appealing party unless the court, after giving such party notice and an opportunity to be heard, determines that such a stay would be detrimental to the interests of policyholders, shareholders, creditors or the public.

(3) Any person aggrieved by any failure of the commissioner to act or make a determination required by this chapter may petition the Chancery Court of the First Judicial District of Hinds County for a writ in the nature of a mandamus or a peremptory mandamus directing the commissioner to act or make such determination forthwith.

HISTORY: Laws, 1974, ch. 366, § 11, eff from and after July 1, 1974.

Cross References — Mandamus generally, see §§ 11-41-1 et seq.

Application of judicial review provisions of this section to determination of commissioner that a person violated Managing General Agents Act, see § 83-18-111.

§ 83-6-43. Certain laws superseded; remedies to be construed as supplemental.

All laws and parts of laws of this state inconsistent with this chapter are hereby superseded with respect to matter covered by this chapter, but all remedies provided herein for protection of policyholders and the public shall be construed as cumulative and supplemental to any remedies now existing under the law.

HISTORY: Laws, 1974, ch. 366, § 12, eff from and after July 1, 1974.

§ 83-6-45. Supervisory colleges.

(1) **Power of commissioner.** With respect to any insurer registered under Section 83-6-3, and in accordance with subsection (3) of this section, the commissioner shall also have the power to participate in a supervisory college for any domestic insurer that is part of an insurance holding company system with international operations in order to determine compliance by the insurer with this chapter. The powers of the commissioner with respect to supervisory colleges include, but are not limited to, the following:

(a) Initiating the establishment of a supervisory college;

(b) Clarifying the membership and participation of other supervisors in the supervisory college;

(c) Clarifying the functions of the supervisory college and the role of other regulators, including the establishment of a group-wide supervisor;

(d) Coordinating the ongoing activities of the supervisory college, including planning meetings, supervisory activities, and processes for information sharing; and

(e) Establishing a crisis management plan.

(2) **Expenses.** Each registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in a supervisory college in accordance with subsection (3) of this section, including reasonable travel expenses. For purposes of this section, a supervisory college may be convened as either a temporary or permanent forum for communication and cooperation between the regulators charged with the supervision of the insurer or its affiliates, and the commissioner may establish a regular assessment to the insurer for the payment of these expenses.

(3) **Supervisory college.** In order to assess the business strategy, financial position, legal and regulatory position, risk exposure, risk management and governance processes, and as part of the examination of individual insurers in accordance with Section 83-6-27, the commissioner may participate in a supervisory college with other regulators charged with supervision of the insurer or its affiliates, including other state, federal and international regulatory agencies. The commissioner may enter into agreements in accordance with the confidentiality provisions of this chapter providing the basis for cooperation between the commissioner and the other regulatory agencies, and the activities of the supervisory college. Nothing in this section shall delegate to the supervisory college the authority of the commissioner to regulate or supervise the insurer or its affiliates within its jurisdiction.

HISTORY: Laws, 2017, ch. 306, § 6, eff from and after passage (approved Mar. 6, 2017).

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-6-47. Group-wide supervision of internationally active insurance groups.

(1) The commissioner is authorized to act as the group-wide supervisor for any internationally active insurance group in accordance with the provisions of this section. However, the commissioner may otherwise acknowledge another regulatory official as the group-wide supervisor where the internationally active insurance group:

(a) Does not have substantial insurance operations in the United States;

(b) Has substantial insurance operations in the United States, but not in this state; or

(c) Has substantial insurance operations in the United States and this state, but the commissioner has determined pursuant to the factors set forth in subsections (2) and (6) of this section that the other regulatory official is the appropriate group-wide supervisor.

An insurance holding company system that does not otherwise qualify as an internationally active insurance group may request that the commissioner make a determination or acknowledgment as to a group-wide supervisor pursuant to this section.

(2) In cooperation with other state, federal and international regulatory agencies, the commissioner will identify a single group-wide supervisor for an internationally active insurance group. The commissioner may determine that the commissioner is the appropriate group-wide supervisor for an internationally active insurance group that conducts substantial insurance operations concentrated in this state. However, the commissioner may acknowledge that a regulatory official from another jurisdiction is the appropriate group-wide supervisor for the internationally active insurance group. The commissioner shall consider the following factors when making a determination or acknowledgment under this subsection:

(a) The place of domicile of the insurers within the internationally active insurance group that hold the largest share of the group's written premiums, assets or liabilities;

(b) The place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group;

(c) The location of the executive offices or largest operational offices of the internationally active insurance group;

(d) Whether another regulatory official is acting or is seeking to act as the group-wide supervisor under a regulatory system that the commissioner determines to be:

(i) Substantially similar to the system of regulation provided under the laws of this state, or

(ii) Otherwise sufficient in terms of providing for group-wide supervision, enterprise risk analysis, and cooperation with other regulatory officials; and

(e) Whether another regulatory official acting or seeking to act as the group-wide supervisor provides the commissioner with reasonably reciprocal recognition and cooperation.

However, a commissioner identified under this section as the group-wide supervisor may determine that it is appropriate to acknowledge another supervisor to serve as the group-wide supervisor. The acknowledgment of the group-wide supervisor shall be made after consideration of the factors listed in paragraphs (a) through (e) of this subsection, and shall be made in cooperation with and subject to the acknowledgment of other regulatory officials involved with supervision of members of the internationally active insurance group, and in consultation with the internationally active insurance group.

(3) Notwithstanding any other provision of law, when another regulatory official is acting as the group-wide supervisor of an internationally active insurance group, the commissioner shall acknowledge that regulatory official as the group-wide supervisor. However, in the event of a material change in the internationally active insurance group that results in:

(a) The internationally active insurance group's insurers domiciled in this state holding the largest share of the group's premiums, assets or liabilities; or

(b) This state being the place of domicile of the top-tiered insurer(s) in the insurance holding company system of the internationally active insurance group, the commissioner shall make a determination or acknowledgment as to the appropriate group-wide supervisor for such an internationally active insurance group pursuant to subsection (2) of this section.

(4) Pursuant to Section 83-6-27, the commissioner is authorized to collect from any insurer registered pursuant to Section 83-6-3 all information necessary to determine whether the commissioner may act as the group-wide supervisor of an internationally active insurance group or if the commissioner may acknowledge another regulatory official to act as the group-wide supervisor. Prior to issuing a determination that an internationally active insurance group is subject to group-wide supervision by the commissioner, the commissioner shall notify the insurer registered pursuant to Section 83-6-3 and the ultimate controlling person within the internationally active insurance group. The internationally active insurance group shall have not less than thirty (30) days to provide the commissioner with additional information pertinent to the pending determination. The commissioner shall publish in the Mississippi Administrative Code and on its Internet website the identity of internationally active insurance groups that the commissioner has determined are subject to group-wide supervision by the commissioner.

(5) If the commissioner is the group-wide supervisor for an internationally active insurance group, the commissioner is authorized to engage in any of the following group-wide supervision activities:

(a) Assess the enterprise risks within the internationally active insurance group to ensure that:

(i) The material financial condition and liquidity risks to the members of the internationally active insurance group that are engaged in the business of insurance are identified by management; and

(ii) Reasonable and effective mitigation measures are in place;

(b) Request, from any member of an internationally active insurance group subject to the commissioner's supervision, information necessary and appropriate to assess enterprise risk, including, but not limited to, information about the members of the internationally active insurance group regarding:

(i) Governance, risk assessment and management;

(ii) Capital adequacy; and

(iii) Material intercompany transactions;

(c) Coordinate and, through the authority of the regulatory officials of the jurisdictions where members of the internationally active insurance group are domiciled, compel development and implementation of reasonable measures designed to ensure that the internationally active insurance group is able to timely recognize and mitigate enterprise risks to members of such internationally active insurance group that are engaged in the business of insurance;

(d) Communicate with other state, federal and international regulatory agencies for members within the internationally active insurance group and share relevant information subject to the confidentiality provisions of this chapter, through supervisory colleges as set forth in Section 83-6-45 or otherwise;

(e) Enter into agreements with or obtain documentation from any insurer registered under Section 83-6-3, any member of the internationally active insurance group, and any other state, federal and international regulatory agencies for members of the internationally active insurance group, providing the basis for or otherwise clarifying the commissioner's role as group-wide supervisor, including provisions for resolving disputes with other regulatory officials. Such agreements or documentation shall not serve as evidence in any proceeding that any insurer or person within an insurance holding company system not domiciled or incorporated in this state is doing business in this state or is otherwise subject to jurisdiction in this state; and

(f) Other group-wide supervision activities, consistent with the authorities and purposes enumerated above, as considered necessary by the commissioner.

(6) If the commissioner acknowledges that another regulatory official from a jurisdiction that is not accredited by the NAIC is the group-wide supervisor, the commissioner is authorized to reasonably cooperate, through supervisory colleges or otherwise, with group-wide supervision undertaken by the group-wide supervisor, provided that:

(a) The commissioner's cooperation is in compliance with the laws of this state; and

(b) The regulatory official acknowledged as the group-wide supervisor also recognizes and cooperates with the commissioner's activities as a group-wide supervisor for other internationally active insurance groups where applicable. Where such recognition and cooperation is not reasonably reciprocal, the commissioner is authorized to refuse recognition and cooperation.

(7) The commissioner is authorized to enter into agreements with or obtain documentation from any insurer registered under Section 83-6-3, any affiliate of the insurer, and other state, federal and international regulatory agencies for members of the internationally active insurance group, that provide the basis for or otherwise clarify a regulatory official's role as group-wide supervisor.

(8) The commissioner may promulgate regulations necessary for the administration of this section.

(9) A registered insurer subject to this section shall be liable for and shall pay the reasonable expenses of the commissioner's participation in the administration of this section, including the engagement of attorneys, actuaries and any other professionals and all reasonable travel expenses.

HISTORY: Laws, 2017, ch. 306, § 7, eff from and after passage (approved Mar. 6, 2017).

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides:
"SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

CHAPTER 7.

LIFE INSURANCE

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Viatical Settlements. 83-7-201
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GENERAL PROVISIONS

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83-7-51. Notice of right to return policy; effect of return.

§ 83-7-1. Life insurance companies defined.

All corporations, associations, partnerships, or individuals doing business in this state under any charter, contract, agreement, or statute of this or any other state involving the payment of money or other things of value to families or representatives of policy and certificate holders or members, conditioned upon the continuance or cessation of human life, or involving an insurance, guaranty, contract, or pledge for the payment of endowments for annuities, or who shall employ agents to solicit such business, shall be deemed to be life insurance companies, shall in all respects be subject to the laws herein made and provided for the government of life insurance companies, and shall not make any such insurance, guaranty, contract, or pledge in this state with any citizen or resident thereof which does not distinctly state the amount of benefits payable, the manner of payment, and the consideration therefor. Any insurance company or agent who shall make, issue, or deliver a policy of life insurance in wilful violation of this section shall pay to the state for each offense Fifty Dollars ($50.00); but such policy shall, nevertheless, be binding upon the companies issuing the same.

HISTORY: Codes, 1892, § 2339; 1906, § 2598; Hemingway's 1917, § 5062; 1930, § 5170; 1942, § 5680.

Cross References — Definition of insurance, see § 83-5-5.

Registration and examination of companies writing ordinary life insurance, see §§ 83-6-1 et seq.

Maximum rates of interest on policy loans, see § 83-7-26.

Conditions of fire insurance contract, see § 83-13-11.

Legal expense insurance, see §§ 83-49-1 et seq.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Terms of contract to be plainly expressed.

1. In general.

War or military clause in life policy requiring written permit from insurer and payment of extra premium in order for policy to remain in force while insured is serving in the army or navy in time of actual war, constitutes an exemption of insurer from liability, and creation of liability under the exempted circumstances would require another contract which insurer is under no obligation to make and which it may decline to do so without reason. White v. Standard Life Ins. Co., 198 Miss. 325, 22 So. 2d 353, 1945 Miss. LEXIS 201 (Miss. 1945).

War clause in life policy requiring written permit from insurer and payment of extra premium in order for policy to remain in force while insured is serving in the army or navy in time of actual war, is not void as violative of this section [Code 1942, § 5680] on ground that the amount of the extra premium to be charged in case such permission is granted is not set out in the policy. White v. Standard Life Ins. Co., 198 Miss. 325, 22 So. 2d 353, 1945 Miss. LEXIS 201 (Miss. 1945).

Annuity policies, though not life insurance policies, are such as a life insurance company is authorized to issue and therefore are subject to the provisions of the statute regulating the business of life insurance companies, and not to the requirements of the blue sky law. Hamilton v. Penn Mut. Life Ins. Co., 196 Miss. 345, 17 So. 2d 278, 1944 Miss. LEXIS 200 (Miss. 1944).

Policy including both death and health and accident benefits constituted "life insurance policy." Universal Life Ins. Co. v. State, 155 Miss. 358, 121 So. 849, 1929 Miss. LEXIS 258 (Miss. 1929).

Fraternal benefit association is a life insurance company. Masonic Ben. Ass'n v. Dotson, 111 Miss. 60, 71 So. 266, 1916 Miss. LEXIS 240 (Miss. 1916).

2. Terms of contract to be plainly expressed.

A survivorship bonus clause, by which it is pledged that a life insurance company will place annually into a fund a specified amount per each given unit of insurance and that on a given anniversary of the policy a proportionate amount of the total fund accumulated on all policies will be paid to the policyholder, does not conform to the requirement that a life insurance policy distinctly state the amount of benefits payable. White v. National Old Line Ins. Co., 203 Miss. 752, 34 So. 2d 234, 1948 Miss. LEXIS 319 (Miss. 1948).

This section [Code 1942, § 5680] requires that the terms of contract of insurance shall be plainly expressed; and while it cannot be expected that all terms which might to denominated as technical shall be eliminated, nevertheless it can be expected and required that when through experience it has been learned that any particular joinder of words or phrases has caused repeated misunderstanding and litigation, these words or phrases shall be discontinued and those of a plainer meaning inserted in lieu thereof. New York Life Ins. Co. v. Nessossis, 189 Miss. 414, 196 So. 766, 1940 Miss. LEXIS 118 (Miss. 1940).

The court refusing to be bound by testimony that the term "has value" and "guaranteed cash surrender value" were understood in the insurance business to mean the same thing and holding that a provision for a surrender charge and the figures contained in the table under the caption of "Guaranteed cash surrender values," did not constitute a fixation of definite and final figures but only a stipulation of minimum amounts. New York Life Ins. Co. v. Nessossis, 189 Miss. 414, 196 So. 766, 1940 Miss. LEXIS 118 (Miss. 1940).

A surrender charge of "not more than 1 and ½ percentum of the face amount of this policy," to be deduced in computing the cash value for paid up nonparticipating term insurance in the event of default in payment of premium and failure to select other options provided in a life insurance policy, was not void under this section [Code 1942, § 5680] where the policy contained a table setting forth the precise cash value of the policy for each year after deduction of the surrender charge, and thereby definitely fixed both the amount of surrender charge and the policy's cash value. Mutual Life Ins. Co. v. Nelson, 184 Miss. 632, 184 So. 636, 186 So. 837, 1938 Miss. LEXIS 313 (Miss. 1938); New York Life Ins. Co. v. Boling, 177 Miss. 172, 169 So. 882, 1936 Miss. LEXIS 232 (Miss. 1936), dismissed, New York L. Ins. Co. v. Alexander, 300 U.S. 637, 57 S. Ct. 506, 81 L. Ed. 854, 1937 U.S. LEXIS 91 (U.S. 1937), dismissed, New York Life Ins. Co. v. Alexander, 300 U.S. 637 (U.S. 1937).

RESEARCH REFERENCES

ALR.

Rights and remedies arising out of delay in passing upon application for insurance. 32 A.L.R.2d 487.

Gift of life insurance policy. 33 A.L.R.2d 273.

Death or injury resulting from insured's voluntary act in taking overdose of medicine, drugs or the like, as caused by accident or accidental means. 52 A.L.R.2d 1083.

Validity and construction of statutes relating to style or prominence with which provisions must be printed in insurance policy. 36 A.L.R.3d 464.

Suicide clause of life or accident insurance as affected by incontestable clause. 37 A.L.R.3d 337.

Conclusiveness of recitation, in delivered insurance policy, that initial premium has been paid. 44 A.L.R.3d 1361.

Liability of insurance agent or broker to insured for misrepresentation of cash surrender value or accumulated value benefits of life insurance policy. 44 A.L.R.4th 1030.

Accident or life insurance: death by autoerotic asphyxiation as accidental. 62 A.L.R.4th 823.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 5-7.

CJS.

44 C.J.S., Insurance §§ 28-31.

Practice References.

Business Insurance Law and Practice Guide, (Matthew Bender).

Business Law Monographs, Volume IN1 – Business Uses of Life Insurance (Matthew Bender).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-7-3. Distinction in same class and rebates prohibited.

No life insurance company doing business in Mississippi shall make any distinction or discrimination in favor of individuals of the same class and equal expectation of life in the amount of payments of premiums or rates charged for policies of life or endowment insurance, or in the dividends or other benefits payable thereon, or in any of the terms and conditions of the contract it makes. Nor shall any such company or any agent thereof make any contract of insurance or agreement as to such contracts other than are plainly expressed in the application and policy issued thereon; nor shall any such company or agent pay or allow as inducements to insurance any rebate of premium payable on the policy, or any special favor or advantage in the dividends or other benefits to accrue thereon, or any valuable consideration or inducement whatever not specified in the policy contract of insurance. Whenever it shall appear to the satisfaction of the commissioner, after a hearing before him upon notice, that any company, officer, agent, subagent, broker, or solicitor has violated any provision of this section, he shall revoke the license of any such company or person to transact business in this state; and no other license shall be issued to any such company or person within one (1) year after such revocation. However, nothing in this section shall prevent a company which transacts industrial life insurance on a weekly payment plan from returning to policyholders who have made a premium payment for a period of at least one (1) year the percentage of premium which the company would otherwise have paid for the weekly collection of such premium; nor shall this section be construed to prevent the taking of a bona fide obligation, with legal interest, in payment of any premium.

HISTORY: Codes, 1906, § 2600; Hemingway's 1917, § 5064; 1930, § 5171; 1942, § 5681.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Discriminatory policy provisions.
3. Discrimination by company or agent.

1. In general.

If there is any doubt as to whether the provision of an industrial limited accident insurance policy means that the bodily injuries must be effected solely by external violent and accidental means, instead of meaning that the death must be effected solely by such means, then the doubt would have to be resolved in favor of the insured since this section [Code 1942, § 5681] renders unenforceable in favor of the insurer any contract of insurance or agreement as to such contracts other than are plainly expressed in the application and policy issued thereon. Standard Life Ins. Co. v. Foster, 210 Miss. 242, 49 So. 2d 391, 1950 Miss. LEXIS 344 (Miss. 1950).

A survivorship bonus clause in a life insurance policy, by which the company is affirmatively bound to pay into a special fund for distribution a fixed amount annually per policy unit, is vitally different from a dividend-sharing provision. White v. National Old Line Ins. Co., 203 Miss. 752, 34 So. 2d 234, 1948 Miss. LEXIS 319 (Miss. 1948).

War or military clause in life policy requiring written permit from insurer and payment of extra premium in order for policy to remain in force while insured is serving in the army or navy in time of actual war, constitutes an exemption of insurer from liability, and creation of liability under the exempted circumstances would require another contract which insurer is under no obligation to make and which it may decline to do without reason. White v. National Old Line Ins. Co., 203 Miss. 752, 34 So. 2d 234, 1948 Miss. LEXIS 319 (Miss. 1948).

War clause in life policy requiring permit from insurer and payment of extra premium in order for policy to remain in force while insured is serving in the army or navy in time of actual war, is not void as violative of this section [Code 1942, § 5681] on ground that the amount of the extra premium to be charged in case such permission is granted is not set out in the policy. White v. Standard Life Ins. Co., 198 Miss. 325, 22 So. 2d 353, 1945 Miss. LEXIS 201 (Miss. 1945).

2. Discriminatory policy provisions.

Life policy provision defining cash surrender value to be the reserve on the face of the policy, less any indebtedness thereon, and less a surrender charge of not more than one and one-half per cent of the face of the policy, as applied to the determination of term insurance upon default of the insured in the payment of premiums and election of other options of the policy, held not to violate a similar statutory provision under Arkansas law. Golightly v. New York Life Ins. Co., 186 Miss. 598, 191 So. 111, 1939 Miss. LEXIS 232 (Miss. 1939).

In determining term insurance under life policy which provided for automatic paidup term insurance upon failure of insured to exercise other options of the policy to the extent that the cash value would purchase such insurance if applied as a net single premium and defined cash value as the reserve for the face amount of the policy and dividend additions less the surrender charge, company was authorized to deduct surrender charge in computing such cash value which was definitely determined by a table, and the provisions of the policy in this respect did not violate this section [Code 1942, § 5681]. Mutual Life Ins. Co. v. Nelson, 184 Miss. 632, 184 So. 636, 186 So. 837, 1938 Miss. LEXIS 313 (Miss. 1938).

Where insured had right to borrow on twenty-year payment life policy, provision denying option to convert policy to paidup policy solely because loan was outstanding held void under statute for discrimination between insurants. McCain v. Lamar Life Ins. Co., 178 Miss. 459, 172 So. 495, 1937 Miss. LEXIS 188 (Miss. 1937).

Where insured had never surrendered policy, and there was no physical, actual surrender of policy, provision for surrender charge of not more than 1 ½ per cent of face of life policy was not enforceable so as to reduce cash surrender value to amount insufficient to keep policy in force to time of insured's death, since surrender charge was not fixed and definite, and hence permitted insurer to discriminate between policyholders of same class as forbidden by statute. New York Life Ins. Co. v. Boling, 177 Miss. 172, 169 So. 882, 1936 Miss. LEXIS 232 (Miss. 1936), dismissed, New York L. Ins. Co. v. Alexander, 300 U.S. 637, 57 S. Ct. 506, 81 L. Ed. 854, 1937 U.S. LEXIS 91 (U.S. 1937), dismissed, New York Life Ins. Co. v. Alexander, 300 U.S. 637 (U.S. 1937).

Clause of life policy under which borrowers, on lapse of policy, were entitled only to amount of extended insurance which available net cash value would purchase, held not unenforceable as creating discrimination against borrowing policyholders. Neal v. Columbian Mut. Life Assurance Soc., 161 Miss. 814, 138 So. 353, 1931 Miss. LEXIS 314 (Miss. 1931).

Insurance policy providing that policyholder would be paid 1% of cash premiums received by company, annually, in consideration of policyholder giving information as to insurance agents and risks, held illegal discrimination. Cole v. State, 91 Miss. 628, 45 So. 11, 1907 Miss. LEXIS 168 (Miss. 1907).

3. Discrimination by company or agent.

Return of insured's note for payment of annual premiums, pursuant to his request for cancelation thereof, and application of policy values to extended insurance from due date of premium for which note was given, did not constitute an illegal rebate of premiums on the theory that life insurer, having accepted insured's note, designed to retain policy in force for another year, was without power to cancel such premiums and thereby fix the original due date as the controlling date for computation of extended insurance and that its attempt to do so constituted an illegal rebate of premiums. Penn Mut. Life Ins. Co. v. Weathersby, 194 Miss. 741, 13 So. 2d 628, 1943 Miss. LEXIS 104 (Miss. 1943).

Member of benefit insurance association held not entitled to recover, as part of agreed disability benefits of "one-half of the face of the certificate," one-half of amount provided elsewhere in certificate "for the erection of a monument to his memory," irrespective of whether in some cases association had included monument benefits in computing disability benefits, since such discrimination would be violative of statute. Sovereign Camp, W. O. W. v. Waggoner, 178 Miss. 418, 173 So. 424, 1937 Miss. LEXIS 223 (Miss. 1937).

Under statute prohibiting discrimination by life insurance companies in favor of individuals and subjecting company to revocation of license for such discrimination, promise of such discrimination is unenforceable. Sovereign Camp, W. O. W. v. Waggoner, 178 Miss. 418, 173 So. 424, 1937 Miss. LEXIS 223 (Miss. 1937).

Agent's agreement to return all of premium except company's share held illegal, and agent's administrator could recover the balance of such premium. Rideout v. Mars, 99 Miss. 199, 54 So. 801, 1911 Miss. LEXIS 190 (Miss. 1911).

RESEARCH REFERENCES

ALR.

State regulation of insurer's right to classify insureds for premium or other underwriting purposes by occupation. 57 A.L.R.4th 625.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 537, 538.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance § 551.

§ 83-7-4. Proceeds of policy; effect of payment when made by insurer or contract issuer in accordance with terms of policy or contract.

Whenever the proceeds of, or payments under, a life insurance policy or annuity contract issued by a life insurance company become payable and the insurer makes payment thereof in accordance with the terms of the policy or contract, or in accordance with any written assignment thereto, the payee or beneficiary shall be entitled to receive the proceeds or payments and to give full acquittance therefor, and the payment shall fully discharge the insurer from all claims under the policy or contract unless, before payment is made, the insurer has received at its home office written notice by or on behalf of some other person that the other person claims to be entitled to the payment or some interest in the policy or contract. Nothing contained in this section shall affect any claim or right to any policy or contract or the proceeds thereof or payment thereunder as between persons other than the insurer.

HISTORY: Laws, 2017, ch. 307, § 1, eff from and after July 1, 2017.

§ 83-7-5. Proceeds of policy not subject to judicial process or assignment while in hands of company.

If, under the terms of any annuity contract, or policy of life insurance, or under any written agreement supplemental thereto issued by any life insurance company, the proceeds are retained by such company at maturity or otherwise, no person entitled to any part of such proceeds, or any installments of interest due or to become due thereon, shall be permitted to commute, anticipate, encumber, alienate, or assign the same, or any part thereof, if such permission is expressly withheld by the terms of such contract, policy, or supplemental agreement. If such contract, policy, or supplemental agreement so provides, no payment of interest or of principal shall be in any way subject to such person's debts, contracts, or engagements, nor to any judicial processes to levy upon or attach the same for payment thereof. No such company shall be required to segregate such funds, but may hold them as a part of its general corporate funds.

HISTORY: Codes, 1930, § 5172; 1942, § 5682; Laws, 1924, ch. 190.

Cross References — Payment of proceeds of life insurance policy, see §§ 85-3-11 et seq.

JUDICIAL DECISIONS

1. In general.

Legislative purpose was to permit insured to provide for wife and dependents in such manner as to prevent proceeds of policies from being applied to their debts, and to prevent anticipation of installments. Adams v. Strong, 171 Miss. 510, 158 So. 204, 1934 Miss. LEXIS 283 (Miss. 1934).

Insurer's monthly payments to beneficiary under life policy held not subject to garnishment where there was no showing of agreement by insurer giving beneficiary right to anticipate benefits, and no such indorsement was ever made on policy as required thereby. Adams v. Strong, 171 Miss. 510, 158 So. 204, 1934 Miss. LEXIS 283 (Miss. 1934).

RESEARCH REFERENCES

ALR.

Rights and remedies arising out of delay in passing upon application for insurance. 32 A.L.R.2d 487.

Rights of creditors of life insured as to options or other benefits available to him during his lifetime. 37 A.L.R.2d 268.

Am. Jur.	**CJS.**
31 Am. Jur. 2d, Exemptions §§ 80 et seq.	35 C.J.S., Exemptions §§ 32 et seq.

§ 83-7-6. Proceeds of policy become due as of date of death of insured; insurers admitted to transact life insurance in Mississippi required to pay interest on proceeds of certain policies; computation of interest; applicability.

(1) Proceeds of a life insurance policy shall become due as of the date of the death of the insured. Each insurer admitted to transact life insurance in this state shall pay interest on proceeds or payments under any policy of life insurance payable to a beneficiary residing in this state or to a beneficiary under a policy issued in this state or to a beneficiary under a policy insuring a person resident in this state at the time of death.

(2) Interest payable under subsection (1) of this section shall be computed from the insured's death until the date of payment and shall be computed at the rate of interest guaranteed by the policy or at the current rate of interest applicable to death proceeds left on deposit with the insurer under an interest settlement option or at the current rate of interest payable on dividends left on deposit with the insurer, whichever is greater.

(3) This section shall be applicable to any such policy where proceeds have not been paid and accepted before May 14, 2004.

(4) This section shall not apply:

(a) When the total death proceeds payable by an insurer on account of the death of an insured person is less than Five Thousand Dollars ($5,000.00); or

(b) When death proceeds result from insurance written under Section 83-53-1 et seq.

HISTORY: Laws, 2004, ch. 564, § 1, eff from and after passage (approved May 14, 2004).

Cross References — Definition of "knowledge of death" for purposes of this section, see § 83-7-305.

Interest payable under this section is not payable as unclaimed property under Section 89-12-7(1) or (3), see § 83-7-307.

§ 83-7-7. Policy beneficiary designations of trustees.

(1) Life insurance may be made payable to a trustee to be named as beneficiary in the policy and the proceeds of such insurance shall be paid to such trustee and shall be held and disposed of by the trustee as provided in a trust agreement made by the insured during his lifetime. It shall not be necessary to the validity of any such trust agreement or declaration of trust that it have a trust corpus other than the right of the trustee to receive such insurance proceeds as beneficiary.

(2) A policy of life insurance may designate as beneficiary a trustee or trustees named by will. The proceeds of such insurance shall be payable to the trustee or trustees to be held and disposed of under the terms of the will as they exist as of the time of the death of the testator. If no such trustee makes claim to the proceeds from the insurance company within eighteen (18) months after the death of the insured, or if satisfactory evidence is furnished to the insurance company within such eighteen-month period showing that there is or will be no trustee to receive the proceeds, payment shall be made by the insurance company to the executors, administrators, or assigns of the insured, unless otherwise provided by agreement with the insurance company during the lifetime of the insured.

(3) The proceeds of the insurance as received by the trustee or trustees shall not be subject to debts of the insured nor to transfer or estate tax to any greater extent than if such proceeds were payable to the beneficiary or beneficiaries named in the trust and not to the estate of the insured.

(4) Such insurance proceeds so held in trust may be commingled with any other assets which may properly come into such trust.

(5) Nothing in this section shall affect the validity of any life insurance policy beneficiary designation heretofore made naming trustees of trusts established by living trust or by will.

HISTORY: Codes, 1942, § 5682.5; Laws, 1966, ch. 526, §§ 1-4, eff from and after passage (approved May 6, 1966).

Cross References — Payment of proceeds of life insurance policies, see §§ 85-3-11 et seq.

JUDICIAL DECISIONS

1. In general.

Where an insured evidences an intent to change the beneficiary, and does all he or she can do to comply with the requirements of the policy, substantial compliance will be found and the change of beneficiary will be upheld. Thus, there was substantial compliance with policy terms requiring that a request for a change of beneficiary be on a written form where the insured made an oral request for a change of beneficiary of a group life insurance policy that she acquired through her employment but her employer's agent did not have a change of beneficiary form for the life insurance policy, and the insured changed the beneficiary on a separate accident insurance policy. Bell v. Parker, 563 So. 2d 594, 1990 Miss. LEXIS 272 (Miss. 1990).

RESEARCH REFERENCES

ALR.

Who is "parent" entitled to proceeds of serviceman's group life insurance, where there are no named beneficiaries, and no surviving widow or children, under 38 USCS § 770(a). 73 A.L.R. Fed. 135.

Am. Jur.

31 Am. Jur. 2d, Exemptions §§ 80 et seq.

CJS.

35 C.J.S., Exemptions §§ 32 et seq.

§ 83-7-9. Assignment of group life insurance policy.

Subject to the terms of the policy or pursuant to an agreement between the insured, the group policyholder, and the insurer, any person insured under a group life insurance policy may make to any other person, other than the policyholder, an assignment of all or any part of the incidents of ownership conferred on him by the policy or by law, including specifically, but not by way of limitation, the right to exercise the conversion privilege and the right to name a beneficiary.

HISTORY: Codes, 1942, § 5682.9; Laws, 1971, ch. 393, § 1, eff from and after passage (approved March 22, 1971).

RESEARCH REFERENCES

ALR.

Change of beneficiary in group life insurance policy as affected by failure to comply with policy requirements as to manner of making change. 78 A.L.R.3d 466.

Who is "parent" entitled to proceeds of serviceman's group life insurance, where there are no named beneficiaries, and no surviving widow or children, under 38 USCS § 770(a). 73 A.L.R. Fed. 135.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 649 et seq.

CJS.

45 C.J.S., Insurance §§ 616 et seq.

§ 83-7-11. Penalty for false statement as to publication.

Any solicitor, agent, examining physician, or other person who shall knowingly or wilfully make any false or fraudulent statement or representation in or with reference to any publication for insurance, or who shall make any such statement for the purpose of obtaining fee, commission, money, or benefit in any corporation transacting business under this chapter, shall be guilty of a misdemeanor and, upon conviction, shall be punished by a fine of not less than One Hundred Dollars ($100.00) nor more than Five Hundred Dollars ($500.00), or imprisonment in the county jail for not less than thirty (30) days.

HISTORY: Codes, 1906, § 2604; Hemingway's 1917, § 5067; 1930, § 5173; 1942, § 5683.

Cross References — Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

RESEARCH REFERENCES

ALR.

Failure to disclose terminal illness as basis for life insurer's avoidance of high-risk, high-premium policy requiring no health warranties or proof of insurability. 42 A.L.R.4th 158.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 74, 78.

23 Am. Jur. Proof of Facts 2d 53, Innocent Misrepresentation of Physical Condition by Applicant for Life or Health Insurance.

CJS.

44 C.J.S., Insurance § 139.

§ 83-7-13. Application of insured to be filed with policy of insurance.

All life insurance companies doing business in the State of Mississippi shall deliver to the insured with the policy, certificate, or contract of insurance in any form a copy of the insured's application; and in default thereof, said life insurance company shall not be permitted in any court of this state to deny that any of the statements in said application are true.

HISTORY: Codes, 1906, § 2675; Hemingway's 1917, § 5141; 1930, § 5174; 1942, § 5684.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Copy of application attached to policy.
3. Delivery of application to insured.

1. In general.

This section [Code 1942, § 5684] was not intended to permit a person to perpetrate a fraud. Moody v. New York Life Ins. Co., 161 F. Supp. 482, 1958 U.S. Dist. LEXIS 2394 (D. Miss. 1958), aff'd, 262 F.2d 588, 1959 U.S. App. LEXIS 4492 (5th Cir. Miss. 1959).

The purpose of this section [Code 1942, § 5684] is to enable the insured to determine at any time by inspection of his policy whether there are any errors contained therein, through inadvertence or otherwise, and to correct them or to disclose the true facts to the insurance company while he is carrying the insurance and before he becomes uninsurable. Moody v. New York Life Ins. Co., 161 F. Supp. 482, 1958 U.S. Dist. LEXIS 2394 (D. Miss. 1958), aff'd, 262 F.2d 588, 1959 U.S. App. LEXIS 4492 (5th Cir. Miss. 1959).

Issue of good health at time of original life policy, which lapsed and was revived upon representation that insured was then in good health, was open without regard to the warranties under the original application. Standard Life Ins. Co. v. Baldwin, 199 Miss. 302, 24 So. 2d 360, 1946 Miss. LEXIS 198 (Miss. 1946).

Statute precluding insurer from denying truth of statements contained in application for policy, unless copy of application is delivered to insured with policy, must be liberally construed for insured's benefit. Aetna Life Ins. Co. v. McCree, 174 Miss. 242, 164 So. 223, 1935 Miss. LEXIS 68 (Miss. 1935).

Having been held by the Supreme Court of Mississippi to be a rule of substantive law and not a rule of evidence, this statute applies to actions removed from a state to a federal court within the state. Great Southern Life Ins. Co. v. Burwell, 12 F.2d 244, 1926 U.S. App. LEXIS 3218 (5th Cir. Miss.), cert. denied, 271 U.S. 683, 46 S. Ct. 633, 70 L. Ed. 1150, 1926 U.S. LEXIS 808 (U.S. 1926).

This section [Code 1942, § 5684] does not apply to mutual benefit societies. Columbian Mut. Life Assurance Soc. v. Harrington, 139 Miss. 826, 104 So. 297, 1925 Miss. LEXIS 168 (Miss. 1925).

The burden of proving defendant an insurer to whom this provision applies is on plaintiff. Columbian Mut. Life Assurance Soc. v. Harrington, 139 Miss. 826, 104 So. 297, 1925 Miss. LEXIS 168 (Miss. 1925).

This section [Code 1942, § 5684] repealed as to fraternal benefit societies in regard to preventing insurer from contradicting statements in application, unless copy thereof was furnished insured. Knights of MacCabees v. Coleman, 128 Miss. 854, 91 So. 561, 1922 Miss. LEXIS 168 (Miss. 1922).

This section [Code 1942, § 5684] held to create a rule of substantive law which becomes a part of contract. Sovereign Camp, Woodmen of World v. Farmer, 116 Miss. 626, 77 So. 655, 1917 Miss. LEXIS 352 (Miss. 1917).

2. Copy of application attached to policy.

Where the application for the original life insurance policy contained false statements by the insured but before the policy was delivered, insurer, at insured's request, issued two policies in the same amount as the original and required the insured to execute a form stating that since making the application for the original policy the insured had not consulted or been treated by any physician, and the policies of new insurance with copy of application attached thereto were delivered to the insured, and the policy provided that the policy and application formed the entire contract, insurer was not precluded from taking advantage of the insured's false statements, even though the form executed prior to the issuance of the new policies was not attached thereto. Moody v. New York Life Ins. Co., 161 F. Supp. 482, 1958 U.S. Dist. LEXIS 2394 (D. Miss. 1958), aff'd, 262 F.2d 588, 1959 U.S. App. LEXIS 4492 (5th Cir. Miss. 1959).

In action on hospitalization policy, failure to attach insured's application to policy as provided in this section [Code 1942, § 5684] does not bar defense that insured's sickness for which hospitalization is claimed was not contracted while policy was in force, that she was not in good health when she received the policy, and that her case was not embraced within provisions for indemnity under policy. American Life Ins. Co. v. Walker, 208 Miss. 1, 43 So. 2d 657, 1949 Miss. LEXIS 401 (Miss. 1949).

Representatives in application for revival of lapsed life policy are competent although not attached to the new policy as required of original policies by this section [Code 1942, § 5684]. Standard Life Ins. Co. v. Baldwin, 199 Miss. 302, 24 So. 2d 360, 1946 Miss. LEXIS 198 (Miss. 1946).

Where part of amended application was not attached to life policy, insurer could not prove statement therein as to consulting physician was false. New York Life Ins. Co. v. Rosso, 154 Miss. 196, 122 So. 382, 1929 Miss. LEXIS 123 (Miss. 1929).

3. Delivery of application to insured.

Failure of an insurer to deliver a copy of the application with a life insurance policy did not estop the insurer from relying on express provisions of the policy that it should be liable only for the amount of the premiums paid if the insured was in sound health at the time the policy was delivered, and from showing that at the time the insured was recovering from tuberculosis, despite the fact that the application represented the insured as in sound health and as never having had tuberculosis. National Life & Acci. Ins. Co. v. Green, 191 Miss. 581, 2 So. 2d 838, 3 So. 2d 812, 1941 Miss. LEXIS 162 (Miss. 1941).

Insurer's failure to send to insured copy of application for reinstatement of lapsed life policy held not to preclude insurer from denying truth of statements in application for reinstatement because of statute requiring life insurance companies to deliver to insured, with policy, copy of insured's application, and in default thereof prohibiting such companies from denying truth of statements in application, since statute has reference to application upon which original policy is issued and not to any reinstatement subsequent to original delivery. Walker v. Acacia Mut. Life Ins. Co., 178 Miss. 395, 173 So. 453, 1937 Miss. LEXIS 229 (Miss. 1937).

Where employee's application for insurance was not delivered to him with insurance certificate, but was attached to master policy delivered to employer, insurer's evidence offered to contradict statements in application held property excluded. Aetna Life Ins. Co. v. McCree, 174 Miss. 242, 164 So. 223, 1935 Miss. LEXIS 68 (Miss. 1935).

Where agent of insurer required to make written application and undergo physical examination to obtain employment took out disability insurance with insurer on basis of application, application was in legal effect "application for insurance," and hence failure of insurer to deliver copy of application to agent with policy precluded insurer from showing in suit on policy that agent's disability was caused by disease contracted before policy was issued. National Life & Acci. Ins. Co. v. Prather, 169 Miss. 898, 153 So. 881, 1934 Miss. LEXIS 81 (Miss. 1934).

Insurer's failure to deliver copy of application with life policy held not to preclude reliance on express conditions appearing in policy itself. Metropolitan Life Ins. Co. v. Scott, 160 Miss. 537, 134 So. 159, 1931 Miss. LEXIS 189 (Miss. 1931).

RESEARCH REFERENCES

ALR.

Rights and remedies arising out of delay in passing upon application for insurance. 32 A.L.R.2d 487.

Insurance: sufficiency of insurer's compliance with statutory requisites as to attaching copy of application to, or making it part of, policy. 18 A.L.R.3d 760.

Insurer's duty, and effect of its failure, to provide insured or payee with copy of policy or other adequate documentation of its terms. 78 A.L.R.4th 9.

Am. Jur.

43 Am. Jur. 2d, Insurance § 314.

CJS.

44 C.J.S., Insurance § 428-431.

§ 83-7-15. Misstatement of age not to invalidate policy.

Any misstatement of age in any policy, certificate, or contract of life insurance in any form shall not invalidate said policy, certificate, or contract of life insurance; but in such a case when a loss occurs, the beneficiaries shall recover on said policy, certificate, or contract of insurance such an amount of insurance as the premiums paid would have purchased for the insured at his actual age, reckoning according to the rate tables of said insurance company.

HISTORY: Codes, 1906, § 2676; Hemingway's 1917, § 5142; 1930, § 5175; 1942, § 5685.

JUDICIAL DECISIONS

1. In general.

A policy provision that if age is not truthfully stated, benefits shall be those which premiums paid would have purchased at the true age does not conflict with this section [Code 1942, § 5685]. Tisdale v. Jefferson Standard Life Ins. Co., 244 Miss. 839, 147 So. 2d 122, 1962 Miss. LEXIS 514 (Miss. 1962).

In an action to recover insurance premiums paid on life insurance policy after insurer had not notified insured that face value of policy would be reduced to an amount that premium would have purchased at the correct age of insured, in accordance with policy provisions and the statutory provision that a misstatement of age shall not invalidate the policy, evidence as to insurer's fraud in securing contract for insurance held insufficient for submission to jury. Metropolitan Life Ins. Co. v. Hall, 152 Miss. 413, 118 So. 826, 1928 Miss. LEXIS 228 (Miss. 1928).

Misstatement of age does not invalidate policy but merely limits recovery to amount which premiums paid would have purchased at insured's actual age. Coplin v. Woodmen of World, 105 Miss. 115, 62 So. 7, 1913 Miss. LEXIS 187 (Miss. 1913).

RESEARCH REFERENCES

ALR.

Calculation of newborn child's age for purposes of life insurance policy requiring that specified age be reached before coverage begins. 37 A.L.R.3d 1448.

Am. Jur.

44 Am. Jur. 2d, Insurance §§ 765 et seq.

23 Am. Jur. Proof of Facts 2d 53, Innocent Misrepresentation of Physical Condition by Applicant for Life or Health Insurance.

CJS.

44 C.J.S., Insurance §§ 381, 382.

§ 83-7-17. Policies to show plainly on face kind and character; fees for commissioner's approval; expedited form and rate review procedure.

(1) All life insurance companies other than fraternal beneficiary associations, authorized to do the business of life insurance in this state, are hereby required to print or stamp in conspicuous type on the face or first page of each and every policy sold to citizens of this state words indicating correctly and fully the kind and character of the policy. The same words shall also be printed or stamped on the back or title page of every such policy so that they may be easily seen and read when the policy is folded. Every such life insurance company shall submit to the commissioner for his approval the words required in this section to be printed on each policy, together with a sample copy of every kind or class of policies offered for sale in this state; and every life insurance company shall print on each of its policies sold to citizens of this state such words as the Insurance Commissioner shall approve. The license of any insurance company doing business in this state may be revoked by the commissioner for violating any of the provisions of this section. A policy of life insurance shall not be issued or delivered in this state until the form has been approved and filed by the Insurance Commissioner.

(2) The commissioner shall collect and pay into the Insurance Department Fund in the State Treasury the following fees for services provided under this section:

FORM	FEE
Each individual policy contract, including revisions	$15.00
Each group master policy or contract, including revisions	15.00
Each rider, endorsement or amendment, etc	10.00
Each insurance application where written application is required and is to be made a part of the policy or contract	10.00
Each questionnaire	7.00
Charge for resubmission where payment is not included with original submission	5.00

Additional charge for tentative approval same as above.

(3) In order to expedite and become more efficient in reviewing and approving life, credit life and annuity form and rate filings, the commissioner may establish an expedited form and rate review procedure whereby insurers may elect to pay reasonable actuarial fees directly to a department-approved actuarial service in exchange for an expedited review of form and rate filings by the actuarial service. The commissioner may make such reasonable rules and regulations concerning the expedited procedure, and may set reasonable fees for the actuarial services provided. This provision shall not abridge any other authority granted to the commissioner by law, including the authority to collect the filing fees prescribed by this section.

HISTORY: Codes, 1906, § 2677; Hemingway's 1917, § 5143; 1930, § 5176; 1942, § 5686; Laws, 1950, ch. 416; Laws, 1988, ch. 526, § 3; Laws, 1997, ch. 324, § 2; Laws, 1998, ch. 323, § 2; Laws, 2008, ch. 432, § 1, eff from and after July 1, 2008.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected an error in the third sentence of (1). The word "a" was inserted preceding "sample," and the word "a" was deleted following "sample" in the third sentence so that "with sample a copy" now reads "with a sample copy." The Joint Committee ratified the correction at its August 5, 2008, meeting.

Editor's Notes — Laws of 1988, ch. 526, § 13, provides as follows:

"SECTION 13. The commissioner may, after notice and hearing, issue rules and regulations that he deems necessary to effectuate the purposes of this act or to eliminate devices or plans designed to avoid or render ineffective the provisions of this act. The commissioner may require such information as is reasonably necessary for the enforcement of this act. All rules and regulations adopted and promulgated pursuant to this act shall be subject to the provisions of the Mississippi Administrative Procedures Law as provided in Section 25-43-1 et seq. [now Section 25-43-1.101 et seq.], Mississippi Code of 1972."

Cross References — Policies issued on co-operative plan, see § 83-25-3.

Conditions for fraternal society to insure children, see § 83-29-73.

JUDICIAL DECISIONS

1. In general.

The power of the insurance commissioner to approve or disapprove life insurance policy provisions is a quasi-judicial power in which he is allowed much latitude, so long as the power is not arbitrarily exercised. White v. National Old Line Ins. Co., 203 Miss. 752, 34 So. 2d 234, 1948 Miss. LEXIS 319 (Miss. 1948).

The insurance commissioner is not estopped by previous approval of the provisions in a life insurance policy from subsequently disapproving such provisions on advice of the attorney general that such provisions do not comply with the law. White v. National Old Line Ins. Co., 203 Miss. 752, 34 So. 2d 234, 1948 Miss. LEXIS 319 (Miss. 1948).

Annuity policies were not void and subject to cancelation at the suit of assured because they were issued and delivered in this state without compliance with this section [Code 1942, § 5686], since they were not policies of life insurance. Hamilton v. Penn Mut. Life Ins. Co., 196 Miss. 345, 17 So. 2d 278, 1944 Miss. LEXIS 200 (Miss. 1944).

Insurance policies providing for monthly income to assured for life were not life insurance policies, within the purview of statute providing that a policy of life insurance shall not be issued or delivered in this state until the form has been approved and filed by the insurance commissioner, but were annuity policies notwithstanding that they also provided for payment to another of the balance, if any, of the single premium remaining at the death of assured. Hamilton v. Penn Mut. Life Ins. Co., 196 Miss. 345, 17 So. 2d 278, 1944 Miss. LEXIS 200 (Miss. 1944).

RESEARCH REFERENCES

ALR.

Incontestability clause as precluding insurer from defending on ground of particular clause in life policy limiting or precluding insurer's liability because of other life insurance. 22 A.L.R.2d 809.

Death or injury resulting from insured's voluntary act in taking overdose of medicine, drugs, or the like, as caused by accident or accidental means. 52 A.L.R.2d 1083.

Validity and construction of statutes

relating to style or prominence with which provisions must be printed in insurance policy. 36 A.L.R.3d 464.

Insurer's duty, and effect of its failure, to provide insured or payee with copy of policy or other adequate documentation of its terms. 78 A.L.R.4th 9.

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.
44 C.J.S., Insurance § 392.

§ 83-7-19. Minors may make insurance contract.

Any minor of the age of fifteen (15) years nearest birthday or more may, notwithstanding such minority, contract for life, health, and accident insurance on his own life for the benefit of his father, mother, husband, wife, child, brother, sister, or any person having an insurable interest in the life of such minor and may, with the approval of the chancery court, contract for life insurance for his benefit on the life of any person owning an estate of any kind in which the minor is to participate or to receive benefits upon the death of such person, either by inheritance or by will. Such minor may exercise all such contractual rights with respect to any such contract of insurance as might be exercised by a person of full legal age and may at any time surrender his or her interest in any such insurance or give a valid discharge for any benefit accruing or money due thereunder.

The guardian of any minor under the age of fifteen (15) years may, with the approval of the chancery court, contract for life insurance for the benefit of his ward on the life of any person under the conditions hereinabove set forth.

HISTORY: Codes, 1930, § 5177; 1942, § 5687; Laws, 1950, ch. 416.

RESEARCH REFERENCES

CJS.
44 C.J.S., Insurance §§ 381, 382.

§ 83-7-21. Reserve liabilities.

The reserve liabilities for all policies in force in any domestic company being ascertained in the manner provided in Section 83-7-23, the Insurance Commissioner shall notify it of the amount. The officers of such company shall deposit with the State Treasurer for the security and benefit of all the policyholders the sum of One Hundred Thousand Dollars ($100,000.00). Provided, this sum may be increased to the amount necessary for a domestic company to be qualified to do business in another state, so long as such state will accept a certificate verified by the State Treasurer of Mississippi showing that such company has on deposit in Mississippi the required sum.

So long as the company continues solvent and complies with the laws of the state, it may collect the income on such securities. The company may substitute therefor other securities recognized by law as lawful investments of the company; provided, however, it shall be the duty of the State Treasurer to accept from such insurance companies securities tendered to him for deposit upon the representation of such companies by their officers or agents that such securities comply with the laws of the State of Mississippi, as provided in this chapter. Once a year the Insurance Commissioner shall examine all of the securities so deposited and all of the securities held as reserves by each company and either approve or disapprove such securities. Should he disapprove any such securities, then such securities shall be replaced by such companies with other securities approved by the Insurance Commissioner, sufficient in amount to comply with the requirement of deposit with the State Treasurer and sufficient in amount under the law. Any fraud on the part of any officer or agent of a company in making any substitution of securities shall be a violation of law and subject any such person to the penalties provided in this chapter.

It is also provided that all bonds or other evidences of debt having a fixed term and rate held by any life insurance company authorized to do business in this state may, if amply secured and not in default as to principal and interest, be valued as follows: if purchased at par, at the par value; if purchased above or below par, on the basis of the purchase price adjusted so as to bring the value to par at maturity and so as to yield in the meantime the effective rate of interest at which the purchase was made; provided that the purchase price shall in no case be taken at a higher figure than the actual market value at the time of purchase; and, provided further that the Insurance Commissioner shall have full discretion in determining the method of calculating values according to the foregoing rule.

When in the opinion of the State Treasurer there is insufficient space in vaults and safes in the Treasury Department in which to keep the securities as provided in this chapter, then the State Treasurer is authorized, empowered, and directed to:

(a) Deposit for safekeeping in the vaults of any of the state or national banks located within this state which are members of the Federal Deposit Insurance Corporation and which have appropriate safekeeping facilities which have been approved by the State Depository Commission, any Federal Reserve bank, any Federal Reserve branch bank, or any bank which is a member of the Federal Reserve system and is located in a city where there is a Federal Reserve branch bank, the securities placed with him by insurance companies; or

(b) Accept, in lieu of the securities themselves, safekeeping trust receipts issued to the State Treasurer by the authorized safekeeping banks located within this state which are members of the Federal Deposit Insurance Corporation and which have appropriate safekeeping facilities which have been approved by the State Depository Commission, such safekeeping trust receipts to describe the securities and show that such securities are held for safekeeping for the account of the State Treasurer. The securities so deposited shall not be commingled in any manner with the assets of the safekeeping bank.

The State Treasurer shall be responsible to such insurance companies for any loss of securities deposited with and actually held by the State Treasurer under the provisions of this chapter.

Notwithstanding any other provision of law, the securities qualified for deposit under this section may be deposited with a clearing corporation or held in the Federal Reserve book-entry system. Securities deposited with a clearing corporation or held in the Federal Reserve book-entry system and used to meet the deposit requirements set forth in this section shall be under the control of the Insurance Commissioner and shall not be withdrawn by the insurance company without the approval of the Insurance Commissioner. Any insurance company holding securities in such manner shall provide to the Insurance Commissioner evidence issued by its custodian or member bank through which such insurance company has deposited such securities in a clearing corporation or through which such securities are held in the Federal Reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian or other direct participant or member bank, and that the records of the custodian, other participant or member bank reflect that such securities are held subject to the order of the Insurance Commissioner.

HISTORY: Codes, 1942, § 5669-01; Laws, 1948, ch. 345, § 1; Laws, 1970, ch. 449, § 1; Laws, 1984, ch. 340; Laws, 1985, ch. 418; Laws, 2001, ch. 412, § 4, eff from and after July 1, 2001.

Editor's Notes — Section 27-105-1 provides that wherever the term "State Depository Commission" appears in any law, the same shall mean the State Treasurer.

Cross References — Duty of state treasurer with respect to securities deposited with him, see § 7-9-9.

Eligibility of securities insured by Federal Housing Administrator, see § 43-33-305.

Legal reserves required of insurance companies, see § 83-5-23.

Computation of liabilities and reserves of insurance companies other than life, see § 83-13-3.

Reserves required of mutual companies, see § 83-31-31.

Securities required of burial associations, see § 83-37-11.

Utilization of modern systems such as clearing corporations and the Federal Reserve book-entry system for the deposit of securities without physical delivery, see §§ 83-67-1 et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 71, 72.

CJS.
44 C.J.S., Insurance §§ 121-123.

§ 83-7-23. Standard valuation law.

(1) **Title and definitions:**

(a) This section shall be known as the Standard Valuation Law.

(b) For the purposes of this section, the following definitions shall apply on or after the operative date of the valuation manual:

(i) The term "accident and health insurance" means contracts that incorporate morbidity risk and provide protection against economic loss resulting from accident, sickness, or medical conditions and as may be specified in the valuation manual.

(ii) The term "appointed actuary" means a qualified actuary who is appointed in accordance with the valuation manual to prepare the actuarial opinion required in subsection (3)(b) of this section.

(iii) The term "company" means an entity, which:

(A) Has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in this state and has at least one (1) such policy in force or on claim; or

(B) Has written, issued, or reinsured life insurance contracts, accident and health insurance contracts, or deposit-type contracts in any state and is required to hold a certificate of authority to write life insurance, accident and health insurance, or deposit-type contracts in this state.

(iv) The term "deposit-type contract" means contracts that do not incorporate mortality or morbidity risks and as may be specified in the valuation manual.

(v) The term "life insurance" means contracts that incorporate mortality risk, including annuity and pure endowment contracts, and as may be specified in the valuation manual.

(vi) The term "NAIC" means the National Association of Insurance Commissioners.

(vii) The term "policyholder behavior" means any action a policyholder, contract holder or any other person with the right to elect options, such as a certificate holder, may take under a policy or contract subject to this section, including, but not limited to, lapse, withdrawal, transfer, deposit, premium payment, loan, annuitization, or benefit elections prescribed by the policy or contract but excluding events of mortality or morbidity that result in benefits prescribed in their essential aspects by the terms of the policy or contract.

(viii) The term "principle-based valuation" means a reserve valuation that uses one or more methods or one or more assumptions determined by the insurer and is required to comply with subsection (12) of this section as specified in the valuation manual.

(ix) The term "qualified actuary" means an individual who is qualified to sign the applicable statement of actuarial opinion in accordance with the American Academy of Actuaries qualification standards for actuaries signing such statements and who meets the requirements specified in the valuation manual.

(x) The term "tail risk" means a risk that occurs either where the frequency of low probability events is higher than expected under a normal probability distribution or where there are observed events of very significant size or magnitude.

(xi) The term "valuation manual" means the manual of valuation instructions adopted by the NAIC as specified in this section or as subsequently amended.

(2) **Reserve valuation:**

(a) Policies and contracts issued prior to the operative date of the valuation manual.

(i) The Insurance Commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state issued on or after April 14, 1948, and prior to the operative date of the valuation manual, except that, in the case of an alien company, such valuation shall be limited to its United States business. In calculating such reserves, the commissioner may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves herein required of any foreign or alien company, the commissioner may accept any valuation made, or caused to be made, by the insurance supervisory official of any other state or other jurisdiction when such other valuation complies with the minimum standard provided in this section.

(ii) The provisions set forth in subsections (3), (3-a), (3-b), (4), (4-a), (5), (6), (7), (8) and (10) of this section shall apply to all policies and contracts, as appropriate, subject to this section issued on or after April 14, 1948, and prior to the operative date of the valuation manual and the provisions set forth in subsections (11) and (12) of this section shall not apply to any such policies and contracts.

(iii) The minimum standard for the valuation of policies and contracts issued prior to April 14, 1948, shall be that provided by the laws in effect immediately prior to that date.

(b) Policies and contracts issued on or after the operative date of the valuation manual:

(i) The commissioner shall annually value, or cause to be valued, the reserve liabilities (hereinafter called reserves) for all outstanding life insurance contracts, annuity and pure endowment contracts, accident and health contracts, and deposit-type contracts of every company issued on or after the operative date of the valuation manual. In lieu of the valuation of the reserves required of a foreign or alien company, the commissioner may accept a valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when the valuation complies with the minimum standard provided in this section.

(ii) The provisions set forth in subsections (11) and (12) of this section shall apply to all policies and contracts issued on or after the operative date of the valuation manual.

(3) **Computation of minimum standard:** Except as otherwise provided in subsections (3-a) and (3-b) of this section the minimum standard for the valuation of all such policies and contracts issued before the operative date of Section 83-7-25 shall be that provided by the laws in effect immediately before such date.

Except as otherwise provided in subsections (3-a) and (3-b) of this section, the minimum standard for the valuation of all such policies and contracts issued on or after the operative date of Section 83-7-25 (the standard nonforfeiture law) shall be the commissioners reserve valuation methods defined in subsections (4), (4-a) and (7) of this section, three and one-half percent (3-½%) interest, or in the case of policies and contracts, other than annuity and pure endowment contracts, issued on or after September 1, 1975, four percent (4%) interest for such policies issued prior to January 1, 1980, five and one-half percent (5-½%) interest for single premium life insurance policies and four and one-half percent (4-½%) interest for all other such policies issued on and after January 1, 1980, and the following tables:

(a) For all ordinary policies of life insurance issued on the standard basis, excluding any disability and accidental death benefits in such policies, – the Commissioners 1941 Standard Ordinary Mortality Table for such policies issued before the operative date of subsection (5-a) of Section 83-7-25 of the Standard Nonforfeiture Law for Life Insurance as amended; the Commissioners 1958 Standard Ordinary Mortality Table for such policies issued on or after the operative date of subsection (5-a) of the Standard Nonforfeiture Law for Life Insurance as amended (Section 83-7-25(5-a)) and before the operative date of subsection (5-c) of the Standard Nonforfeiture Law for Life Insurance as amended (Section 83-7-25(5-c)), provided that for any category of such policies issued on female risks all modified net premiums and present values referred to in this section may be calculated according to an age not more than six (6) years younger than the actual age of the insured; and for such policies issued on or after the operative date of subsection (5-c) of the Standard Nonforfeiture Law for Life Insurance as amended (Section 83-7-25(5-c)):

(i) The Commissioners 1980 Standard Ordinary Mortality Table, or

(ii) At the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors, or

(iii) Any ordinary mortality table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.

(b) For industrial life insurance policies issued on the standard basis, excluding any disability and accidental death benefits in such policies, – the 1941 Standard Industrial Mortality Table for such policies issued prior to the operative date of subsection (5-b) of Section 83-7-25, the Standard Nonforfeiture Law for Life Insurance as amended, and for such policies issued on or after such operative date the Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table, adopted after 1980 by the

NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.

(c) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the 1937 Standard Annuity Mortality Table or, at the option of the company, the Annuity Mortality Table for 1949, Ultimate, or any modification of either of these tables approved by the commissioner.

(d) For group annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies, the Group Annuity Mortality Table for 1951, any modification of such table approved by the commissioner, or, at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(e) For total and permanent disability benefits in or supplementary to ordinary policies or contracts, – for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates, adopted after 1980 by the NAIC, which are approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables or, at the option of the company, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(f) For accidental death benefits in or supplementary to policies – for policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such policies; for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(g) For group life insurance, life insurance issued on the substandard basis and other special benefits – such tables as may be approved by the commissioner.

(3-a) **Computation of minimum standard for annuities:**

(a) Except as provided in subsection (3-b), the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this subsection (3-a), as defined herein, and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the commissioner's reserve valuation methods defined in subsections (4) and (4-a) of this section and the following tables and interest rates:

(i) For individual annuity and pure endowment contracts, issued before January 1, 1980, excluding any disability and accidental death benefits in such contracts, – the 1971 Individual Annuity Mortality Table, or any modification of this table approved by the commissioner, and six percent (6%) interest for single premium immediate annuity contracts, and four percent (4%) interest for all other individual annuity and pure endowment contracts.

(ii) For individual single premium immediate annuity contracts issued on or after January 1, 1980, excluding any disability and accidental death benefits in such contracts, – the 1971 Individual Annuity Mortality Table, or any individual annuity mortality table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and seven and one-half percent (7-½%) interest.

(iii) For individual annuity and pure endowment contracts issued on or after January 1, 1980, other than single premium immediate annuity contracts, excluding any disability and accidental death benefits in such contracts, the 1971 Individual Annuity Mortality Table, or any individual annuity mortality table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such contracts, or any modification of these tables approved by the commissioner, and five and one-half percent (5-½%) interest for single premium deferred annuity and pure endowment contracts and four and one-half percent (4-½%) interest for all other such individual annuity and pure endowment contracts.

(iv) For all annuities and pure endowments purchased prior to January 1, 1980, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any modification of this table approved by the commissioner, and six percent (6%) interest.

(v) For all annuities and pure endowments purchased on or after January 1, 1980, under group annuity and pure endowment contracts, excluding any disability and accidental death benefits purchased under such contracts, the 1971 Group Annuity Mortality Table, or any group annuity mortality table, adopted after 1980 by the NAIC, which is approved by regulation promulgated by the commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments, or any modification of these tables approved by the commissioner, and seven and one-half percent (7-½%) interest.

(b) After September 1, 1975, any insurer may file with the commissioner a written notice of its election to comply with the provisions of this subsection (3-a) after a specified date before January 1, 1979, which shall be the operative date of this subsection for such insurer, provided an insurer may elect a different operative date for individual annuity and pure endowment contracts from that elected for group annuity and pure endowment contracts. If an insurer makes no such election, the operative date of this subsection for such insurer shall be January 1, 1979.

(3-b) **Computation of minimum standard by calendar year of issue:**

(a) Applicability of this subsection. The interest rates used in determining the minimum standard for the valuation of the following shall be the calendar year statutory valuation interest rates as defined in this subsection:

(i) Life insurance policies issued in a particular calendar year, on or after the operative date of Section (5-c) of the Standard Nonforfeiture Law for Life Insurance (Section 83-7-25(5-c));

(ii) Individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1984;

(iii) Annuities and pure endowments purchased in a particular calendar year on or after January 1, 1984, under group annuity and pure endowment contracts; and

(iv) The net increase, if any, in a particular calendar year after January 1, 1984, in amounts held under guaranteed interest contracts shall be the calendar year statutory valuation interest rates as defined in this subsection.

(b) Calendar year statutory valuation interest rates.

(i) The calendar year statutory valuation interest rates, I, shall be determined as follows and the results rounded to the nearer one-quarter of one percent (¼ of 1%):

(A) For life insurance,

$I =.03 + W (R1 -.03) + W/2 (R2 -.09)$;

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options,

$I =.03 + W (R -.03)$

where R1 is the lesser of R and.09, R2 is the greater of R and.09, R is the reference interest rate defined in this section, and W is the weighting factor defined in this section;

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in (B) above, the formula for life insurance stated in (A) above shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of ten (10) years and the formula for single premium immediate annuities stated in (B) above shall apply to annuities and guaranteed interest contracts with guarantee duration of ten (10) years or less;

(D) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in (B) above shall apply;

(E) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in (B) above shall apply.

(ii) However, if the calendar year statutory valuation interest rate for any life insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of one percent (½ of 1%), the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980 (using the reference interest rate defined for 1979) and shall be determined for each subsequent calendar year regardless of when Section (5-c) of the Standard Nonforfeiture Law for Life Insurance (Section 83-7-25(5-c)) becomes operative.

(c) Weighting factors.

(i) The weighting factors referred to in the formulas stated above are given in the following tables:

(A) Weighting factors for life insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less	.50
More than 10, but not more than 20	.45
More than 20	.35

For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy;

(B) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options:

.80

(C) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in (B) above, shall be as specified in tables 1, 2 and 3 below, according to the rules and definitions in 4 and 5 below:

1. For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factor for Plan Type		
	A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

2. For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in 1 above increased by:

Plan Type		
A	B	C
.15	.25	.05

3. For annuities and guaranteed interest contracts valued on an issue year basis (other than those with no cash settlement options) which do not guarantee interest on considerations received more than one (1) year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than twelve (12) months beyond the valuation date, the factors shown in 1 or derived in 2 increased by:

Plan Type		
A	B	C
.05	.05	.05

4. For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of twenty (20) years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guarantee duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

5. Plan type as used in the above tables is defined as follows:

Plan Type A: At any time policyholder may withdraw funds only (1) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without such adjustment but in installments over five (5) years or more, or (3) as an immediate life annuity, or (4) no withdrawal permitted.

Plan Type B: Before expiration of the interest rate guarantee, policyholder may withdraw funds only (1) with adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) without such adjustment but in installments over five (5) years or more, or (3) no withdrawal permitted. At the end of interest rate guarantee funds may be withdrawn without such adjustment in a single sum or installments over less than five (5) years.

Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five (5) years either (1) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company, or (2) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(ii) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options must be valued on an issue year basis. As used in this subsection, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(d) Reference interest rate.

(i) The reference interest rate referred to in paragraph (b) of this subsection shall be defined as follows:

(A) For all life insurance, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year next preceding the year of issue, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(B) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or year of purchase of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(C) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in (B) above, with guarantee duration in excess of ten (10) years, the lesser of the average over a period of thirty-six (36) months and the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(D) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in (B) above, with guarantee duration of ten (10) years or less, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(E) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of twelve (12) months, ending on June 30 of the calendar year of issue or purchase, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(F) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in (B) above, the average over a period of twelve (12) months, ending on June 30 of the calendar year of the change in the fund, of the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc.

(e) Alternative method for determining reference interest rates.

In the event that the monthly average of the composite yield on seasoned corporate bonds, is no longer published by Moody's Investors Service, Inc., or in the event that the NAIC determines that the monthly average of the composite yield on seasoned corporate bonds, as published by Moody's Investors Service, Inc., is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by regulation promulgated by the commissioner, may be substituted.

(4) **Reserve valuation method-life insurance and endowment benefits:** Except as otherwise provided in subsections (4-a) and (7), reserves according to the commissioners reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums, shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract

premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of (a) over (b), as follows:

(a) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one (1) per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium shall not exceed the net level annual premium on the nineteen-year premium whole life plan for insurance of the same amount at an age one (1) year higher than the age at issue of such policy.

(b) A net one-year term premium for such benefits provided for in the first policy year.

Provided that for any life insurance policy issued on or after January 1, 1987, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioners reserve valuation method as of any policy anniversary occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in subsection (7), be the greater of the reserve as of such policy anniversary calculated as described in the preceding paragraph and the reserve as of such policy anniversary calculated as described in that paragraph, but with (i) the value defined in subparagraph (a) of that paragraph being reduced by fifteen percent (15%) of the amount of such excess first year premium, (ii) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date, (iii) the policy being assumed to mature on such date as an endowment, and (iv) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in subsections (3-a) and (3-b) shall be used.

Reserves according to the commissioners reserve valuation method for: (i) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums; (ii) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended; (iii) disability and accidental death benefits in all policies and contracts; and (iv) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of the preceding paragraphs of this subsection.

(4-a) **Reserve valuation method-annuity and pure endowment benefits:** This subsection shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer (including a partnership or sole proprietorship) or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408 of the Internal Revenue Code, as now or hereafter amended.

Reserves according to the commissioners annuity reserve method for benefits under annuity or pure endowment contracts, excluding any disability and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

(5) **Minimum reserves:** In no event shall a company's aggregate reserves for all life insurance policies, excluding disability and accidental death benefits, issued on or after the operative date of the standard nonforfeiture law (Section 83-7-25), be less than the aggregate reserves calculated in accordance with the methods set forth in subsections (4), (4-a), (7) and (8) and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

(6) **Optional reserve calculation:** Reserves for all policies and contracts issued prior to the effective date of Section 83-7-25 (the standard nonforfeiture law) may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to such date.

Reserves for any category of policies, contracts or benefits as established by the commissioner, issued on or after the operative date of Section 83-7-25 (the standard nonforfeiture law), may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, shall not be greater than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided for in the policies or contracts.

Any company which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided may, with the approval of the commissioner, adopt any lower standard of valuation, but not lower than the minimum herein provided.

(7) **Reserve calculation-valuation net premium exceeding the gross premium charges:** If in any contract year the gross premium charged by any life insurance company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon, but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in subsections (3) and (3-b).

Provided that for any life insurance policy issued on or after January 1, 1987, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this subsection (7) shall be applied as if the method actually used in calculating the reserve for such policy were the method described in subsection (4), ignoring the second paragraph of subsection (4). The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with subsection (4), including the second paragraph of that subsection, and the minimum reserve calculated in accordance with this subsection (7).

(8) **Reserve calculation-indeterminate premium plans:** In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in subsections (4), (4-a) and (7), the reserves which are held under any such plan must:

(a) Be appropriate in relation to the benefits and the pattern of premiums for that plan, and

(b) Be computed by a method which is consistent with the principles of this Standard Valuation Law as determined by regulations promulgated by the commissioner.

(9) **Actuarial opinion of reserves:**

(a) Actuarial opinion prior to the operative date of the valuation manual.

(i) General. Every life insurance company doing business in this state annually shall submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The commissioner by regulation shall define the specifics of this opinion and add any other items deemed to be necessary to its scope.

(ii) Actuarial analysis of reserves and assets supporting reserves.

(A) Every life insurance company, except as exempted by or in accordance with regulation, shall also annually include in the opinion required by paragraph (a) of this subsection an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by regulation, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(B) The commissioner may provide by regulation for a transition period for establishing any higher reserves which the qualified actuary may deem necessary in order to render the opinion required by this subsection.

(iii) Each opinion required by subparagraph (ii) of this subsection (9)(a) shall be governed by the following provisions:

(A) A memorandum, in form and substance acceptable to the commissioner as specified by regulation, shall be prepared to support each actuarial opinion.

(B) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by regulation or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the regulations or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the commissioner.

(iv) Every opinion required by this subsection (9)(a) shall be governed by the following provisions:

(A) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after December 31, 1994.

(B) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by regulation.

(C) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the commissioner may by regulation prescribe.

(D) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(E) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth in such regulations.

(F) Except in cases of fraud or willful misconduct, the qualified actuary shall not be liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision or conduct with respect to the actuary's opinion.

(G) Disciplinary action by the commissioner against the company or the qualified actuary shall be defined in regulations by the commissioner.

(H) Any memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection therewith, shall be kept confidential by the commissioner and shall not be made public and shall not be subject to subpoena, other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or by regulations promulgated hereunder; however, the memorandum or other material may otherwise be released by the commissioner with the written consent of the company or to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited by the company in its marketing or is cited before any governmental agency other than a state insurance department or is released by the company to the news media, all portions of the confidential memorandum shall be no longer confidential.

(b) Actuarial opinion of reserves after the operative date of the valuation manual.

(i) General. Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this state and subject to regulation by the commissioner shall annually submit the opinion of the appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts are computed appropriately, are based on assumptions that satisfy contractual provisions, are consistent with prior reported amounts and comply with applicable laws of this state. The valuation manual will prescribe the specifics of this opinion including any items deemed to be necessary to its scope.

(ii) Actuarial analysis of reserves and assets supporting reserves. Every company with outstanding life insurance contracts, accident and health insurance contracts or deposit-type contracts in this state and subject to regulation by the commissioner, except as exempted in the valuation manual, shall also annually include in the opinion required by subparagraph (i) of this subsection (9)(b), an opinion of the same appointed actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified in the valuation manual, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including, but not limited to, the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including, but not limited to, the benefits under and expenses associated with the policies and contracts.

(iii) Each opinion required by subparagraph (ii) of this subsection (9)(b) shall be governed by the following provisions:

(A) A memorandum, in form and substance as specified in the valuation manual, and acceptable to the commissioner, shall be prepared to support each actuarial opinion.

(B) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified in the valuation manual or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the valuation manual or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare the supporting memorandum required by the commissioner.

(iv) Requirements for all opinions subject to this subsection (9)(b):

(A) The opinion shall be in form and substance as specified in the valuation manual and acceptable to the commissioner.

(B) The opinion shall be submitted with the annual statement reflecting the valuation of such reserve liabilities for each year ending on or after the operative date of the valuation manual.

(C) The opinion shall apply to all policies and contracts subject to subparagraph (ii) of this subsection (9)(b), plus other actuarial liabilities as may be specified in the valuation manual.

(D) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board or its successor, and on such additional standards as may be prescribed in the valuation manual.

(E) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(F) Except in cases of fraud or willful misconduct, the appointed actuary shall not be liable for damages to any person (other than the insurance company and the commissioner) for any act, error, omission, decision or conduct with respect to the appointed actuary's opinion.

(G) Disciplinary action by the commissioner against the company or the appointed actuary shall be defined in regulations by the commissioner.

(10) For accident and health insurance contracts issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (2)(b). For accident and health insurance contracts issued on or after April 14, 1948, and prior to the operative date of the valuation manual, the minimum standard valuation is the standard prescribed by the applicable laws and regulations of this state.

(11) **Valuation manual for policies issued on or after the operative date of the valuation manual:**

(a) For policies issued on or after the operative date of the valuation manual, the standard prescribed in the valuation manual is the minimum standard of valuation required under subsection (2)(b), except as provided under paragraph (e) or (g) of this subsection.

(b) The operative date of the valuation manual is January 1 of the first calendar year following the first July 1 as of which all of the following have occurred:

(i) The valuation manual has been adopted by the NAIC by an affirmative vote of at least forty-two (42) members, or three-fourths (¾) of the members voting, whichever is greater.

(ii) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by states representing greater than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements submitted for 2008: life, accident and health annual statements; health annual statements; or fraternal annual statements.

(iii) The Standard Valuation Law, as amended by the NAIC in 2009, or legislation including substantially similar terms and provisions, has been enacted by at least forty-two (42) of the following fifty-five (55) jurisdictions: The fifty (50) States of the United States, American Samoa, the American Virgin Islands, the District of Columbia, Guam, and Puerto Rico.

(c) Unless a change in the valuation manual specifies a later effective date, changes to the valuation manual shall be effective on January 1 following the date when change to the valuation manual has been adopted by the NAIC by an affirmative vote representing:

(i) At least three-fourths (¾) of the members of the NAIC voting, but not less than a majority of the total membership; and

(ii) Members of the NAIC representing jurisdictions totaling greater than seventy-five percent (75%) of the direct premiums written as reported in the following annual statements most recently available prior to the vote in subparagraph (i) of this subsection (11)(c): life, accident and health annual statements, health annual statements, or fraternal annual statements.

(d) The valuation manual must specify all of the following:

(i) Minimum valuation standards for and definitions of the policies or contracts subject to subsection (2)(b). Such minimum valuation standards shall be:

(A) The commissioner's reserve valuation method for life insurance contracts, other than annuity contracts, subject to subsection (2)(b);

(B) The commissioners annuity reserve valuation method for annuity contracts subject to subsection (2)(b); and

(C) Minimum reserves for all other policies or contracts subject to subsection (2)(b).

(ii) Which policies or contracts or types of policies or contracts that are subject to the requirements of a principle-based valuation in subsection (12)(a) and the minimum valuation standards consistent with those requirements;

(iii) For policies and contracts subject to a principle-based valuation under subsection (12):

(A) Requirements for the format of reports to the commissioner under subsection (12)(b)(iii) and which shall include information necessary to determine if the valuation is appropriate and in compliance with this section;

(B) Assumptions shall be prescribed for risks over which the company does not have significant control or influence.

(C) Procedures for corporate governance and oversight of the actuarial function, and a process for appropriate waiver or modification of such procedures.

(iv) For policies not subject to a principle-based valuation under subsection (12) the minimum valuation standard shall either:

(A) Be consistent with the minimum standard of valuation prior to the operative date of the valuation manual; or

(B) Develop reserves that quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring.

(v) Other requirements, including, but not limited to, those relating to reserve methods, models for measuring risk, generation of economic scenarios, assumptions, margins, use of company experience, risk measurement, disclosure, certifications, reports, actuarial opinions and memorandums, transition rules and internal controls; and

(vi) The data and form of the data required under subsection (13), with whom the data must be submitted, and may specify other requirements including data analyses and reporting of analyses.

(e) In the absence of a specific valuation requirement or if a specific valuation requirement in the valuation manual is not, in the opinion of the commissioner, in compliance with this section, then the company shall, with respect to such requirements, comply with minimum valuation standards prescribed by the commissioner by regulation.

(f) The commissioner may engage a qualified actuary, at the expense of the company, to perform an actuarial examination of the company and opine on the appropriateness of any reserve assumption or method used by the company, or to review and opine on a company's compliance with any requirement set forth in this section. The commissioner may rely upon the opinion, regarding provisions contained within this section, of a qualified actuary engaged by the commissioner of another state, district or territory of the United States. As used in this paragraph, the term "engage" includes employment and contracting.

(g) The commissioner may require a company to change any assumption or method that in the opinion of the commissioner is necessary in order to comply with the requirements of the valuation manual or this section; and the company shall adjust the reserves as required by the commissioner. The commissioner may take other disciplinary action as permitted.

(12) **Requirements of a principle-based valuation:**

(a) A company must establish reserves using a principle-based valuation that meets the following conditions for policies or contracts as specified in the valuation manual:

(i) Quantify the benefits and guarantees, and the funding, associated with the contracts and their risks at a level of conservatism that reflects conditions that include unfavorable events that have a reasonable probability of occurring during the lifetime of the contracts. For polices or contracts with significant tail risk, reflects conditions appropriately adverse to quantify the tail risk.

(ii) Incorporate assumptions, risk analysis methods and financial models and management techniques that are consistent with, but not necessarily identical to, those utilized within the company's overall risk-assessment process, while recognizing potential differences in financial reporting structures and any prescribed assumptions or methods.

(iii) Incorporate assumptions that are derived in one (1) of the following manners:

(A) The assumption is prescribed in the valuation manual.

(B) For assumptions that are not prescribed, the assumptions shall:

1. Be established utilizing the company's available experience, to the extent it is relevant and statistically credible; or

2. To the extent that company data is not available, relevant, or statistically credible, be established utilizing other relevant, statistically credible experience.

(iv) Provide margins for uncertainty including adverse deviation and estimation error, such that the greater the uncertainty the larger the margin and resulting reserve.

(b) A company using a principle-based valuation for one or more policies or contracts subject to this subsection as specified in the valuation manual shall:

(i) Establish procedures for corporate governance and oversight of the actuarial valuation function consistent with those described in the valuation manual.

(ii) Provide to the commissioner and the board of directors an annual certification of the effectiveness of the internal controls with respect to the principle-based valuation. Such controls shall be designed to assure that all material risks inherent in the liabilities and associated assets subject to such valuation are included in the valuation, and that valuations are made in accordance with the valuation manual. The certification shall be based on the controls in place as of the end of the preceding calendar year.

(iii) Develop, and file with the commissioner upon request, a principle-based valuation report that complies with standards prescribed in the valuation manual.

(c) A principle-based valuation may include a prescribed formulaic reserve component.

(13) Experience reporting for policies in force on or after the operative date of the valuation manual.

(a) A company shall submit mortality, morbidity, policyholder behavior, or expense experience and other data as prescribed in the valuation manual.

(b) Experience reporting required by paragraph (a) of this subsection; actuarial memorandums required by subsection (9)(b); reserve examinations, and materials in support thereof, required by subsection (11)(f); materials supporting certification required by subsection (12)(b)(ii); and principle based reserve reports required by subsection (12)(b)(iii) are memorandum in support of the opinion and other material provided by the company to the commissioner in connection therewith, and are subject to subsection (9)(a)(iv)(H) of this section.

(14) **Sharing of information.**

(a) In order to assist in the performance of the commissioner's duties, the commissioner, at his option, may share information obtained pursuant to this section with other state, federal and international regulatory agencies and with the NAIC and its affiliates and subsidiaries, with the Actuarial Board for Counseling and Discipline or its successor, and with state, federal and international law enforcement officials.

(b) The commissioner may receive documents, materials, data and other information, including otherwise confidential and privileged documents, materials, data or information, from the NAIC and its affiliates and subsidiaries, from regulatory or law enforcement officials of other foreign or domestic jurisdictions and from the Actuarial Board for Counseling and Discipline or its successor and shall maintain as confidential or privileged any document, material, data or other information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the data, document, material or other information, and such information shall be treated by all courts in this state as privileged and confidential as it would be treated under the laws of the jurisdiction that is the source of such data, document, material or other information.

(c) The commissioner may enter into agreements governing sharing and use of information consistent with this section.

(d) In this subsection (14) "regulatory agency," "law enforcement agency" and the "NAIC" include, but are not limited to, their employees, agents, consultants and contractors.

(15) **Single state exemption.**

(a) The commissioner may exempt specific product forms or product lines of a domestic company that is licensed and doing business only in Mississippi from the requirements of subsection (11) provided:

(i) The commissioner has issued an exemption in writing to the company and has not subsequently revoked the exemption in writing; and

(ii) The company computes reserves using assumptions and methods used prior to the operative date of the valuation manual in addition to any requirements established by the commissioner and promulgated by regulation.

(b) For any company granted an exemption under this subsection, subsections (3), (3-a), (3-b), (4), (4-a), (5), (6), (7), (8), (9) and (10) shall be applicable. With respect to any company applying this exemption, any reference to subsection (11) found in subsections (3), (3-a), (3-b), (4), (4-a), (5), (6), (7), (8), (9) and (10) shall not be applicable.

HISTORY: Codes, 1942, § 5669-02; Laws, 1948, ch. 345, § 2; Laws, 1962, ch. 460, § 1; Laws, 1966, ch. 523, § 1; Laws, 1975, ch. 412, § 1; Laws, 1979, ch. 314, § 1; Laws, 1983, ch. 316, § 1; Laws, 1994, ch. 314, § 1; Laws, 2014, ch. 410, § 1, eff from and after July 1, 2014.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "subparagraph (ii) of this subsection (9)(a)" for "subsection (9)(a)(ii) of this subsection" in (9)(a)(iii); substituted "this subsection (9)(a)" for "subsection (9)(a)" in (9)(a)(iv); substituted "subparagraph (ii) of this subsection (9)(b)" for "subsection (9)(b)(ii)" in (9)(b)(iii); substituted "this subsection (9)(b)" for "subsection (9)(b)" in (9)(b)(iv); substituted "subparagraph (ii) of this subsection (9)(b)" for "subsection (9)(b)(ii)" in (9)(b)(iv)(C); substituted "subparagraph (i) of this subsection (11)(c)" for "subsection (c)(i)(A)" in (11)(c)(ii); and substituted "subsection (9)(a)(iv)(H)" for "subsection (9)(a)(iii)(H)" in (13)(b). The Joint Committee ratified the correction at its August 10, 2022, meeting.

Cross References — Provisions relative to requirement of a deposit with the State Treasurer as part of the reserve liabilities of domestic life insurance companies, see § 83-7-21.

Standard nonforfeiture law for life insurance, see § 83-7-25.

Federal Aspects — Section 408 of the Internal Revenue Code, see 26 USCS § 408.

RESEARCH REFERENCES

ALR.
Theory of waiver as applicable where provisions of policy or acts of insurer are inconsistent with statutory requirements. 9 A.L.R.2d 1436.

Am. Jur.
43 Am. Jur. 2d, Insurance § 71.

CJS.
44 C.J.S., Insurance §§ 121-123.

Law Reviews.
1979 Mississippi Supreme Court Review: Insurance. 50 Miss. L. J. 813.

§ 83-7-25. Standard nonforfeiture law.

(1) **Title:** This section shall be known as the standard nonforfeiture law for life insurance.

(1-a) **Definitions:** The term "operative date of the valuation manual" means the January 1 of the first calendar year that the valuation manual as defined in Section 83-7-23 is effective.

(2) **Nonforfeiture provisions:** In the case of policies issued on or after the operative date of this section as defined in subsection (10), no policy of life insurance, except as stated in subsection (9), shall be delivered or issued for delivery in this state unless it shall contain in substance the following provisions, or corresponding provisions which in the opinion of the Commissioner of Insurance are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements hereinafter specified and are essentially in compliance with subsection (8) of this section:

(a) That, in the event of default in any premium payment, the company will grant, upon proper request not later than sixty (60) days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as may be hereinafter specified.

In lieu of such stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than sixty (60) days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.

(b) That, upon surrender of the policy within sixty (60) days after the due date of any premium payment in default after premiums have been paid for at least three (3) full years in the case of ordinary insurance or five (5) full years in the case of industrial insurance, the company will pay, in lieu of any paid-up nonforfeiture benefit, a cash surrender value of such amount as may be hereinafter specified.

(c) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than sixty (60) days after the due date of the premium in default.

(d) That, if the policy shall have become paid up by completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company will pay, upon surrender of the policy within thirty (30) days after any policy anniversary, a cash surrender value of such amount as may be hereinafter specified.

(e) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of all other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefits available under the policy, together with a table showing the cash surrender value, if any, and paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first twenty (20) policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

(f) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated therein, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

The company shall reserve the right to defer the payment of any cash surrender value for a period of six (6) months after demand therefor with surrender of the policy.

(3) **Computation of cash surrender value:** Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by subsection (2), shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no

default, over the sum of (1) the then present value of the adjusted premiums as defined in subsections (5), (5-a), (5-b) and (5-c), corresponding to premiums which would have fallen due on and after such anniversary, and (2) the amount of any indebtedness to the company on the policy.

Provided, however, that for any policy issued on or after the operative date of subsection (5-c) as defined therein, which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in the first paragraph of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

Provided, further, that for any family policy issued on or after the operative date of subsection (5-c) as defined therein, which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age of seventy-one (71) years, the cash surrender value referred to in the first paragraph of this subsection shall be an amount not less than the sum of the cash surrender value as defined in such paragraph for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in such paragraph for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

Any cash surrender value available within thirty (30) days after any policy anniversary under any policy paid up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by subsection (2), shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by an indebtedness to the company on the policy.

(4) **Computation of paid-up nonforfeiture benefits:** Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

(5) **Calculation of adjusted premiums:** This subsection (5) shall not apply to policies issued on or after the operative date of subsection (5-c) as defined therein. Except as provided in the third paragraph of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts stated in the policy as extra premiums to cover impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to

the sum of (1) the then present value of the future guaranteed benefits provided for by the policy; (2) two percent (2%) of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount, as hereinafter defined, if the amount of insurance varies with duration of the policy; (3) forty percent (40%) of the adjusted premium for the first policy year; (4) twenty-five percent (25%) of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less. Provided, however, that in applying the percentages specified in (3) and (4) above, no adjusted premium shall be deemed to exceed four percent (4%) of the amount of insurance or level amount equivalent thereto. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent level amount thereof for the purpose of this subsection shall be deemed to be the level amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy.

The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to (a) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits, increased, during the period for which premiums for such term insurance benefits are payable, by (b) the adjusted premiums for such term insurance, the foregoing items (a) and (b) being calculated separately and as specified in the first two (2) paragraphs of this subsection except that, for the purposes of (2), (3) and (4) of the first such paragraph, the amount of insurance or equivalent uniform amount of insurance used in the calculation of the adjusted premiums referred to in (b) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (a).

Except as otherwise provided in subsections (5-a) and (5-b), all adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of the Commissioners 1941 Standard Ordinary Mortality Table, provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three (3) years younger than the actual age of the insured, and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding three and one-half percent (3-½%) per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than one hundred thirty percent (130%) of the rates of mortality according to such applicable table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present value may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

(5-a) **Calculation of adjusted premiums-ordinary policies:** This subsection (5-a) shall not apply to ordinary policies issued on or after the operative date of subsection (5-c) as defined therein. In the case of ordinary policies issued on or after the operative date of this subsection (5-a) as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1958 Standard Ordinary Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits provided that such rate of interest shall not exceed three and one-half percent (3-½%) per annum except that a rate of interest not exceeding four percent (4%) per annum may be used for policies issued on or after September 1, 1975, and prior to January 1, 1980, and a rate of interest not exceeding five and one-half percent (5-½%) per annum may be used for policies issued on or after January 1, 1980, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent (6-½%) per annum may be used and provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six (6) years younger than the actual age of the insured. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1958 Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

After the effective date of this subsection (5-a), any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1966. After the filing of such notice, then upon such specified date (which shall be the operative date of this subsection for such company), this subsection shall become operative with respect to the ordinary policies thereafter issued by such company. If a company makes no such election, the operative date of this subsection for such company shall be January 1, 1966.

(5-b) **Calculation of adjusted premiums-industrial policies:** This subsection (5-b) shall not apply to industrial policies issued on or after the operative date of subsection (5-c) as defined therein. In the case of industrial policies issued on or after the operative date of this subsection (5-b) as defined herein, all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided that such rate of interest shall not exceed three and one-half percent (3-½%) per annum, except that a rate of interest not exceeding four percent (4%) per annum may be used for policies issued on or after September 1, 1975, and prior to January 1, 1980, and a rate of interest not exceeding five and one-half percent (5-½%) per annum may be used for policies issued on or after January 1, 1980, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding six and one-half percent (6-½%) per annum may be used. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1961 Industrial Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculations of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

After the effective date of this subsection (5-b), any company may file with the commissioner a written notice of its election to comply with the provisions of this subsection after a specified date before January 1, 1968. After the filing of such notice, then upon such specified date (which shall be the operative date of this subsection for such company), this subsection shall become operative with respect to the industrial policies thereafter issued by such company. If a company makes no such election, the operative date of this subsection for such company shall be January 1, 1968.

(5-c) **Calculation of adjusted premiums by the nonforfeiture net level premium method:**

(a) This subsection shall apply to all policies issued on or after the operative date of this subsection (5-c) as defined herein. Except as provided in paragraph (g) of this subsection, the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of the policy, of all adjusted premiums shall be equal to the sum of (i) the then present value of the future guaranteed benefits provided for by the policy; (ii) one percent (1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and (iii) one hundred twenty-five percent (125%) of the nonforfeiture net level premium as hereinafter defined. Provided, however, that in applying the percentage specified in (iii) above no nonforfeiture net level premium shall be deemed to exceed four percent (4%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years. The date of issue of a policy for the purpose of this subsection shall be the date as of which the rated age of the insured is determined.

(b) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one (1) per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(c) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(d) Except as otherwise provided in paragraph (g) of this subsection, the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of (A) the sum of (i) the then present value of the then future guaranteed benefits provided for by the policy and (ii) the additional expense allowance, if any, over (B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(e) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of (i) one percent (1%) of the excess, if positive, of the average amount of insurance at the beginning of each of the first ten (10) policy years subsequent to the change over the average amount of insurance prior to the change at the beginning of each of the first ten (10) policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and (ii) one hundred twenty-five percent (125%) of the increase, if positive, in the nonforfeiture net level premium.

(f) The recalculated nonforfeiture net level premium shall be equal to the result obtained by dividing (A) by (B) where:

(A) Equals the sum of

(i) The nonforfeiture net level premium applicable prior to the change times the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred, and

(ii) The present value of the increase in future guaranteed benefits provided for by the policy, and

(B) Equals the present value of an annuity of one (1) per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(g) Notwithstanding any other provisions of this subsection to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(h) All adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of (i) the Commissioners 1980 Standard Ordinary Mortality Table or (ii) at the election of the insurer for any one or more specified plans of life insurance, the Commissioners 1980 Standard Ordinary Mortality Table with ten-year select mortality factors; shall for all policies of industrial insurance be calculated on the basis of the Commissioners 1961 Standard Industrial Mortality Table; and shall for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in this subsection for policies issued in that calendar year. Provided, however, that:

(i) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in this subsection, for policies issued in the immediately preceding calendar year.

(ii) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by subsection (2), shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(iii) A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit including any paid-up additions under the policy on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(iv) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioners 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioners 1961 Industrial Extended Term Insurance Table for policies of industrial insurance.

(v) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.

(vi) For policies issued prior to the operative date of the valuation manual, any commissioner's standard ordinary mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without ten-year select mortality factors or for the Commissioners 1980 Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the standard ordinary mortality table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioners 1980 Extended Term Insurance Table. If the commissioner approves by regulation any commissioner's standard ordinary mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(vii) For policies issued prior to the operative date of the valuation manual, any commissioner's standard industrial mortality tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by regulation promulgated by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. For policies issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioner's Standard Mortality Table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioners 1961 Standard Industrial Mortality Table or the Commissioners 1961 Industrial Extended Term Insurance Table. If the commissioner approves by regulation any commissioner's standard industrial mortality table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(i) The nonforfeiture interest rate is defined below:

(i) For policies issued prior to the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be equal to one hundred twenty-five percent (125%) of the calendar year statutory valuation interest rate for such policy as defined in the Standard Valuation Law (Section 83-7-23), rounded to the nearer one-quarter of one percent (¼ of 1%); provided, however, that the nonforfeiture interest rate shall not be less than four percent (4%).

(ii) For policies issued on and after the operative date of the valuation manual the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

(j) Notwithstanding any other provision in this section to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which involves only a change in the interest rate or mortality table used to compute nonforfeiture values shall not require refiling of any other provisions of that policy form.

(k) After the effective date of this subsection (5-c), any company may file with the commissioner a written notice of its election to comply with the provision s of this subsection after a specified date before January 1, 1989, which shall be the operative date of this subsection for such company. If a company makes no such election, the operative date of this subsection for such company shall be January 1, 1989.

(6) **Nonforfeiture benefits for indeterminate premium plans:** In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance which is of such a nature that minimum values cannot be determined by the methods described in subsection (2), (3), (4), (5), (5-a), (5-b) or (5-c) herein, then:

(a) The commissioner must be satisfied that the benefits provided under the plan are substantially as favorable to policyholders and insured as the minimum benefits otherwise required by subsection (2), (3), (4), (5), (5-a), (5-b) or (5-c) herein;

(b) The commissioner must be satisfied that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds;

(c) The cash surrender values and paid-up nonforfeiture benefits provided by such plan must not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Standard Nonforfeiture Law for life insurance, as determined by regulations promulgated by the commissioner.

(7) **Proration of values; net value of paid-up additions:** Any cash surrender value and any paid-up nonforfeiture benefits, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary. All values referred to in subsections (3), (4), (5), (5-a), (5-b) and (5-c) may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death. The net value of any paid-up additions, other than paid-up term additions, shall be not less than the amounts used to

provide such additions. Notwithstanding the provisions of subsection (3), additional benefits payable (i) in the event of death or dismemberment by accident or accidental means, (ii) in the event of total and permanent disability, (iii) as reversionary annuity or deferred reversionary annuity benefits, (iv) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply, (v) as term insurance on the life of a parent of the child, if such term insurance expires before the child's age is twenty-six (26) years, is uniform in amount after the child's age is one (1) year, and has not become paid up by reason of the death of a parent of the child, and (vi) as other policy benefits additional to life insurance and endowment benefits, and premiums for all such additional benefits, shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(8) **Consistency of progression of cash surrender values with increasing policy duration:** This subsection (8), in addition to all other applicable subsections of this section, shall apply to all policies issued on or after January 1, 1987. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than two-tenths of one percent (2/10 of 1%) of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years, from the sum of (a) the greater of zero and the basic cash value hereinafter specified, and (b) the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

The basic cash value shall be equal to the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as hereinafter defined, corresponding to premiums which would have fallen due on and after such anniversary. Provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in subsection (3), shall be the same as are the effects specified in subsection (3), on the cash surrender values defined in that subsection.

The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in subsection (5-c). Except as is required by the next succeeding sentence of this paragraph, such percentage:

(a) Must be the same percentage for each policy year between the second policy anniversary and the later of (i) the fifth policy anniversary and (ii) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least two-tenths of one percent (2/10 of 1%) in amount, or the average amount of insurance at the beginning of each of the first ten (10) policy years; and

(b) Must be such that no percentage after the later of the two (2) policy anniversaries specified in the preceding paragraph (a) may apply to fewer than five (5) consecutive policy years.

Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in subsection (5-c), were substituted for the nonforfeiture factors in the calculation of the basic cash value.

All adjusted premiums and present values referred to in this subsection shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this section. The cash surrender values referred to in this subsection shall include any endowment benefits provided for by the policy.

Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners consistent with the manners specified for determining the analogous minimum amounts in subsections (2), (3), (4), (5-c) and (7). The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as items (i) through (vi) in subsection (7) shall conform with the principles of this subsection (8).

(9) **Exceptions:** This section shall not apply to any of the following:

(a) Reinsurance,

(b) Group insurance,

(c) Pure endowment,

(d) Annuity or reversionary annuity contract,

(e) Term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy,

(f) Term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in subsections (5), (5-a), (5-b) and (5-c), is less than the adjusted premium so calculated on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance and for a term of twenty (20) years or less expiring before age seventy-one (71), for which uniform premiums are payable during the entire term of the policy,

(g) Policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in subsections (3), (4), (5), (5-a), (5-b) and (5-c), exceeds two and one-half percent (2-½%) of the amount of insurance at the beginning of the same policy year, nor

(h) Policy which shall be delivered outside this state through an agent or other representative of the company issuing the policy.

For purposes of determining the applicability of this section, the age at expiry for a joint term life insurance policy shall be the age at expiry of the oldest life.

(10) **Effective date:** After the effective date of this section, any company may file with the commissioner a written notice of its election to comply with the provisions of this section after a specified date before April 1, 1948. After the filing of such notice, then upon such specified date (which shall be the operative date for such company) this section shall become operative with respect to the policies thereafter issued by such company. If a company makes no such election, the operative date of this section for such company shall be April 1, 1948.

HISTORY: Codes, 1942, § 5669-03; Laws, 1948, ch. 345, § 3; Laws, 1962, ch. 460, § 2; Laws, 1966, ch. 523, § 2; Laws, 1975, ch. 412, § 2; Laws, 1979, ch. 314, § 2; Laws, 1983, ch. 316, § 2; Laws, 2014, ch. 410, § 2, eff from and after July 1, 2014.

Cross References — Standard valuation of life insurance policies, see § 83-7-23.

RESEARCH REFERENCES

ALR.

Theory of waiver as applicable where provisions of policy or acts of insurer are inconsistent with statutory requirements. 9 A.L.R.2d 1436.

CJS.

44 C.J.S., Insurance § 393.

45 C.J.S., Insurance §§ 956-960.

Law Reviews.

1979 Mississippi Supreme Court Review: Insurance. 50 Miss. L. J. 813.

§ 83-7-26. Maximum rate of interest on policy loans; determination; changes in rates; notification to policyholder.

(1) A life insurance policy which provides for policy loans shall contain a provision concerning maximum policy loan interest rates as follows:

(a) A provision permitting a maximum interest rate of not more than eight percent (8%) per annum; or

(b) A provision permitting an adjustable maximum interest rate established from time to time by the life insurer as hereinafter determined. The rate of interest charged on a policy loan made under this paragraph (b) shall not exceed the higher of the following:

(i) The rate used to compute the cash surrender values under the policy during the applicable period, plus one percent (1%) per annum; or

(ii) Moody's Corporate Bond Yield Average-Monthly Average Corporates, as published by Moody's Investors Service, Inc., or any successor thereto. In the event that Moody's Corporate Bond Yield Average-Monthly Average Corporates is no longer published, a substantially similar average established by regulation issued by the commissioner shall be used.

(2) If the maximum rate of interest is determined pursuant to subsection (1)(b) of this section, the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy. Such maximum

rate must be determined at regular intervals at least once every twelve (12) months, but not more frequently than once in any period of three (3) months.

(3) At the intervals specified in the policy pursuant to subsection (2) of this section:

(a) The rate being charged may be increased as permitted by subsection (1)(b) of this section whenever such increase would be one-half of one percent (½ of 1%) or more per annum.

(b) The rate being charged must be reduced whenever such reduction as determined under subsection (1)(b) of this section would decrease that rate by one-half percent (½%) or more per annum.

(4) The life insurer shall:

(a) Notify the policyholder of the initial rate of interest on the loan at the time a cash loan is made.

(b) Notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan. Notice need not be given to the policyholder when a further premium loan is added, except as provided in paragraph (c) of this subsection.

(c) Send to policyholders with loans reasonable advance notice of any increase in the rate.

(d) Include in notices under this subsection the substance of the pertinent provisions of subsections (1) and (2) of this section.

(5) The loan value of the policy shall be determined in a manner consistent with Chapter 7, Title 83, Mississippi Code of 1972, but no policy shall terminate in a policy year as the sole result of a change in the interest rate during that policy year, and the life insurer shall maintain coverage during that policy year until the time at which it would otherwise have terminated if there had been no change during that policy year.

(6) The pertinent provisions of subsections (1) and (2) of this section shall be set forth in substance in the policies to which they apply.

(7) For purposes of this section:

(a) The rate of interest on policy loans permitted under this section includes the interest rate charged on reinstatement of policy loans for the period during and after any lapse of a policy.

(b) The term "policy loan" includes any premium loan made under a policy to pay one or more premiums that were not paid to the life insurer as they fell due.

(c) The term "policyholder" includes the owner of the policy or the person designated to pay premiums as shown on the records of the life insurer.

(d) The term "policy" includes certificates issued by a fraternal benefit society and annuity contracts which provide for policy loans.

(8) No other law of this state shall apply to policy loan interest rates unless made specifically applicable to such rates.

(9) The provisions of this section shall not apply to any insurance contract issued before January 1, 1984.

HISTORY: Laws, 1983, ch. 309, eff from and after January 1, 1984.

§ 83-7-27. Separate accounts to fund pension or profit sharing plans or to provide for life insurance or annuities.

Any domestic life insurance company may establish one (1) or more separate accounts, and may allocate thereto amounts (including without limitation proceeds applied under optional modes of settlement or under dividend options) to fund pension or profit sharing plans or to provide for life insurance or annuities (and benefits incidental thereto), payable in fixed or variable amounts or both.

HISTORY: Codes, 1942, § 5649-31; Laws, 1968, ch. 475, § 1; Laws, 1978, ch. 457, § 1, eff from and after July 1, 1978.

§ 83-7-29. Investment of amounts allocated to separate accounts.

(1) Except as may be provided with respect to reserves for guaranteed benefits and funds referred to in subsection (2) of this section:

(a) amounts allocated to any separate account and accumulations thereon may be invested and reinvested without regard to any requirements or limitations prescribed by the laws of this state governing the investments of life insurance companies; and

(b) the investments in such separate account or accounts shall not be taken into account in applying the investment limitations otherwise applicable to the investments of the company.

(2) Except with the approval of the commissioner of insurance and under such conditions as to investments and other matters as he may prescribe, which shall recognize the guaranteed nature of the benefits provided, reserves for:

(a) benefits guaranteed, as to dollar amount and duration; and

(b) funds guaranteed as to principal amount or stated rate of interest shall not be maintained in a separate account.

(3) No sale, exchange or other transfer of assets may be made by a company between any of its separate accounts or between any other investment account and one (1) or more of its separate accounts unless, in case of a transfer into a separate account, such transfer is made solely to establish the account or to support the operation of the contracts with respect to the separate account to which the transfer is made, and unless such transfer, whether into or from a separate account is made:

(a) by a transfer of cash; or

(b) by a transfer of securities having a readily determinable market value, provided that such transfer of securities is approved by the commissioner of insurance. The commissioner of insurance may approve other transfers among such accounts if, in his opinion, such transfers would not be inequitable.

HISTORY: Codes, 1942, § 5649-32; Laws, 1968, ch. 475, § 2; 178, ch. 457, § 2, eff from and after July 1, 1978.

RESEARCH REFERENCES

CJS.
44 C.J.S., Insurance § 154-156.

§ 83-7-31. Crediting of income or charging of losses on separate accounts.

The income, gains and losses, realized or unrealized, from assets allocated to a separate account shall be credited to or charged against the account without regard to other income, gains or losses of the company.

HISTORY: Codes, 1942, § 5649-33; Laws, 1968, ch. 475, § 3; Laws, 1978, ch. 457, § 3, eff from and after July 1, 1978.

§ 83-7-33. Valuation of assets allocated to separate accounts.

Unless otherwise approved by the commissioner of insurance, assets allocated to a separate account shall be valued at their market value on the date of valuation, or if there is not readily available market, then in accordance with the terms of the contract or the rules or other written agreement applicable to such separate account; provided, that unless otherwise approved by the commissioner of insurance, that portion if any of the assets of such separate account equal to the company's reserve liability with regard to the guaranteed benefits and funds referred to in Section 83-7-29, if any, shall be valued in accordance with the rules otherwise applicable to the company's assets.

HISTORY: Codes, 1942, § 5649-34; Laws, 1968, ch. 475, § 4; Laws, 1978, ch. 457, § 4, eff from and after July 1, 1978.

§ 83-7-35. Ownership of amounts allocated to separate accounts.

The amounts allocated to a separate account in the exercise of the power granted by Sections 83-7-27 through 83-7-49 shall be owned by the company, and the company shall not be, or hold itself out to be, a trustee with respect to such amounts. To the extent so provided under the applicable contracts, that portion of the assets of any such separate account equal to the reserves and other contract liabilities with respect to such account shall not be chargeable with liabilities arising out of any other business the company may conduct.

HISTORY: Codes, 1942, § 5649-35; Laws, 1968, ch. 475, § 5; Laws, 1978, ch. 457, § 5, eff from and after July 1, 1978.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 108.

CJS.
44 C.J.S., Insurance §§ 157, 158.

§ 83-7-37. Powers of domestic companies establishing separate accounts.

To the extent any domestic life company deems it necessary to comply with any applicable federal or state law, such company, with respect to any separate account, including without limitation any separate account which is a management investment company or a unit investment trust, may provide for persons having an interest therein appropriate voting and other rights and special procedures for the conduct of the business of such account, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of independent public accountants, and the selection of a committee, the members of which need not be otherwise affiliated with such company, to manage the business of such account.

HISTORY: Codes, 1942, § 5649-36; Laws, 1968, ch. 475, § 6, 1978, ch. 457, § 6, eff from and after July 1, 1978.

§ 83-7-39. Reserve liability for variable contracts.

The reserve liability for variable contracts shall be established in accordance with actuarial procedures which recognize the variable nature of the benefits to be provided and any mortality guarantees.

HISTORY: Codes, 1942 § 5649-37; Laws, 1968, ch. 475 § 7; Laws, 1978, ch. 457, § 7, eff from and after July 1, 1978.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 71.

CJS.
44 C.J.S., Insurance §§ 159-161.

§ 83-7-41. Contents of contract delivered or issued for delivery in state providing for benefits in variable amounts.

If any contract delivered or issued for delivery in this state provides for payment of benefits in variable amounts, it shall contain a statement of the essential features of the procedure to be followed by the insurance company in determining the dollar amounts of such variable benefits. Any such contract under which the benefits vary to reflect investment experience, including a group contract and any certificate in evidence of variable benefits issued thereunder, shall state that such dollar amount will so vary and shall contain on its first page a statement that the benefits thereunder are on a variable basis.

HISTORY: Codes, 1942, § 5649-38; Laws, 1968, ch. 475, § 8; Laws, 1978, ch. 457, § 8, eff from and after July 1, 1978.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

§ 83-7-43. Authority to deliver or issue for delivery within state contracts providing for benefits in variable amounts.

No domestic life insurance company and no other life insurance company shall deliver or issue for delivery within this state, variable contracts unless it is licensed or organized to do a life insurance or annuity business in this state, and has satisfied the commissioner of insurance that its condition or method of operation in connection with the issuance of such contracts will not render its operation hazardous to the public or its policyholders in this state. In this connection, the commissioner of insurance shall consider among other things:

(a) the history and financial condition of the company;

(b) the character, responsibility and general fitness of the officers and directors of the company; and

(c) the law and regulation under which the company is authorized in the state of domicile to issue variable contracts. The state of entry of an alien company shall be deemed its place of domicile for this purpose.

If the company is a subsidiary of an admitted life insurance company, or affiliated with such company through common management or ownership, it may be deemed by the commissioner of insurance to have met the provisions of this section if either it or the parent or the affiliated company meets the requirements hereof.

HISTORY: Codes, 1942, § 5649-39; Laws, 1968, ch. 475, § 9; Laws, 1978, ch. 457, § 9, eff from and after July 1, 1978.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-7-45. Authority of commissioner to regulate issuance and sale of contracts for separate accounts and those who issue and sell them.

Notwithstanding any other provision of law, the commissioner of insurance shall have sole and exclusive authority to regulate the issuance and sale of contracts for which separate accounts may be established, the insurers which issue them and the agents or other persons who sell them. The commissioner of insurance also shall have the sole authority to issue such reasonable rules and regulations as may be appropriate to carry out the purposes and provisions of Sections 83-7-27 through 83-7-49, including rules and regulations applicable to the licensing and qualification of agents or other persons who sell such contracts.

HISTORY: Codes, 1942, § 5649-40; Laws, 1968, ch. 475, § 10; Laws, 1978, ch. 457, § 10, eff from and after July 1, 1978.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 75.	44 C.J.S. Insurance § 138.

§ 83-7-47. Repealed.

Repealed by Laws, 1978, ch. 457, § 12, eff from and after July 1, 1978.
§ 83-7-47. [Codes, 1942, § 5649-41; Laws, 1968, ch. 475, § 11]

Editor's Notes — Former § 83-7-47 required registration of separate funds.

§ 83-7-49. Application of insurance laws to separate accounts; contents of individual variable life insurance contracts.

Except for Section 83-7-25 of the insurance law in the case of a variable life insurance policy and except as otherwise provided in Sections 83-7-27 through 83-7-49, all pertinent provisions of the insurance laws of this state shall apply to separate accounts and contracts issued in connection therewith. Any individual variable life insurance contract, delivered or issued for delivery in this state shall contain nonforfeiture provisions appropriate to such a contract.

HISTORY: Codes, 1942, § 5649-42; Laws, 1968, ch. 475, § 12; Laws, 1978, ch. 457, § 11, eff from and after July 1, 1978.

§ 83-7-51. Notice of right to return policy; effect of return.

Every individual life insurance policy or contract issued for delivery in the State of Mississippi on or after July 1, 1989, by an insurance company or association shall have printed thereon or attached thereto a notice stating, in substance, that the person to whom the policy or contract is issued shall be permitted to return the policy or contract within ten (10) days of its delivery to said purchaser and to have the premium paid refunded if, after examination of the policy or contract, the purchaser is not satisfied with it for any reason. If a policyholder or purchaser, pursuant to such notice, returns the policy or contract to the insurance company or association at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning, and the parties shall be in the same position as if no policy or service contract had been issued.

HISTORY: Laws, 1989, ch. 340, § 1, eff from and after July 1, 1989.

RESEARCH REFERENCES

ALR.

Insurer's duty, and effect of its failure, to provide insured or payee with copy of policy or other adequate documentation of its terms. 78 A.L.R.4th 9.

ACCELERATED BENEFITS

Sec.

83-7-101. Definitions.
83-7-103. Accelerated benefit provisions as not representing morbidity risks.
83-7-105. Acknowledgement of concurrence for payout prior to payment.
83-7-107. Options for payment; minimum amounts.
83-7-109. Requirement that name given coverage be descriptive of coverage provided; disclosure of information; signatures.
83-7-111. Effective date of accelerated benefit.
83-7-113. Waiver of premium.
83-7-115. Discrimination amongst insureds prohibited.
83-7-117. Disclosure to consumer of any separate identifiable premium for accelerated benefit; options; examples; pro rata reduction in cash value; non-interest bearing lien against death benefit of policy; accidental death benefit not affected by accelerated benefit.
83-7-119. Filing valuation method and assumptions with Department of Insurance; content.

§ 83-7-101. Definitions.

(a) "Accelerated benefits" are benefits payable under a life insurance contract:

(i) To a policy owner, during the lifetime of the insured, in anticipation of death or upon the occurrence of specified life-threatening or catastrophic conditions as defined by the policy or rider;

(ii) Which reduce the death benefit otherwise payable under the life insurance contract (excluding accidental death and other ancillary benefits); and

(iii) Which are payable, in a lump sum or in periodic payments, at the option of the insured.

(b) "Qualifying event" means one or more of the following:

(i) A medical condition which would result in a drastically limited life span, for example, twenty-four (24) months or less;

(ii) A medical condition which has required or requires extraordinary medical intervention, such as, but not limited to, major organ transplant or continuous artificial life support, without which the insured would die;

(iii) A medical condition which would, in the absence of extensive or extraordinary medical treatment, result in a drastically limited life span. Such conditions may include, but are not limited to, one or more of the following:

1. Coronary artery disease resulting in an acute infarction or requiring surgery;

2. Permanent neurological deficit resulting from cerebral vascular accident;

3. End stage renal failure; or

4. Other qualifying event which the Commissioner of Insurance shall approve for any particular filing.

HISTORY: Laws, 1991, ch. 464, § 1, eff from and after July 1, 1991.

RESEARCH REFERENCES

Practice References.

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

Business Law Monographs, Volume IN1—Business Uses of Life Insurance (Matthew Bender Elite Products).

§ 83-7-103. Accelerated benefit provisions as not representing morbidity risks.

Accelerated benefit riders and life insurance policies with accelerated benefit provisions do not represent morbidity risks.

HISTORY: Laws, 1991, ch. 464, § 2, eff from and after July 1, 1991.

§ 83-7-105. Acknowledgement of concurrence for payout prior to payment.

Prior to the payment of the accelerated benefit, the insurer shall receive from any assignee or irrevocable beneficiary a signed acknowledgement of concurrence for payout.

HISTORY: Laws, 1991, ch. 464, § 3, eff from and after July 1, 1991.

§ 83-7-107. Options for payment; minimum amounts.

The benefit shall be paid in a lump sum, or in periodic payments for a fixed period of time, or in a fixed amount for an indefinite period of time, at the option of the insured. Companies may set minimums on the face amount of contracts for which the benefit shall be offered.

HISTORY: Laws, 1991, ch. 464, § 4, eff from and after July 1, 1991.

§ 83-7-109. Requirement that name given coverage be descriptive of coverage provided; disclosure of information; signatures.

(1) The name given the coverage must be descriptive of the coverage provided, and the terminology "accelerated benefit" shall be included in the description.

(2) Clear disclosure is required at the time of application for the policy and at the time the accelerated benefit payment request is submitted of the

potential tax implications of receiving this payout. The disclosure statement shall indicate that receipt of these accelerated benefits may be taxable, and insured should seek assistance from their personal tax advisor. Such disclosure shall be prominently displayed on the first page of the policy or rider and any other related documents.

(3) Prior to or concurrently with the application, the applicant shall be given an illustration numerically demonstrating the effect of the payment of a benefit on the policy's cash value, death benefit, premium, policy loans and policy liens. In the event of direct mail solicitations, the disclosure shall be made upon acceptance of the application.

(4) Prior to or concurrently with the application, the applicant shall be given a written disclosure including, but not necessarily limited to, a brief description of the accelerated benefit and definitions of the conditions or occurrences triggering payment of the benefits. The disclosure shall be signed by the applicant, the policy owner and writing agent. In the event of direct mail solicitations, the disclosure shall be made upon acceptance of the application.

(5) This statement shall appear on the face of every policy or rider: "Cash values, loan values and the death benefit will be reduced if you receive an accelerated benefit." For policies which have no cash or loan values, this statement shall be appropriately modified.

HISTORY: Laws, 1991, ch. 464, § 5, eff from and after July 1, 1991.

§ 83-7-111. Effective date of accelerated benefit.

The accelerated benefit shall be effective on the effective date of the policy or rider.

HISTORY: Laws, 1991, ch. 464, § 6, eff from and after July 1, 1991.

§ 83-7-113. Waiver of premium.

The accelerated benefit provision may or may not provide for the waiver of premium in the absence of a regular waiver of premium provision being in effect. At the time the benefit is claimed, the company shall explain any continuing premium requirement to keep the policy in force.

HISTORY: Laws, 1991, ch. 464, § 7, eff from and after July 1, 1991.

§ 83-7-115. Discrimination amongst insureds prohibited.

Insurers shall not unfairly discriminate among insureds with differing qualifying events or among insureds with similar qualifying events. Insurers shall not apply further conditions on the payment of the accelerated benefits other than those conditions specified in the policy or rider.

HISTORY: Laws, 1991, ch. 464, § 8, eff from and after July 1, 1991.

§ 83-7-117. Disclosure to consumer of any separate identifiable premium for accelerated benefit; options; examples; pro rata reduction in cash value; non-interest bearing lien against death benefit of policy; accidental death benefit not affected by accelerated benefit.

(1) The company shall disclose to the consumer any separate identifiable premium for the accelerated benefit. Those companies indicating that this accelerated benefit is offered without additional premium shall furnish a written explanation to the State Insurance Department when filing the product.

(2) Two (2) options are available to finance the benefit:

(a) The insured may make an additional premium payment or cost of insurance charge; or

(b) The insured may take a present value of the face amount. The calculation would be based on any applicable actuarial discount appropriate to the policy design.

(3) Companies are required to illustrate, by numerical example, any effect the payment of the accelerated benefit has on the face amount, specified amount, accumulation account, cash values, loan balance and future premiums. Each time an accelerated benefit payment is paid, the company is required to send a statement to the policy owner showing the numerical expression stated in this subsection. Upon the payment of an accelerated benefit amount, the company shall issue an endorsement to the policy to reflect any new, reduced, in-force face amount of the contract.

(4)(a) When an accelerated benefit is payable, the NAIC preference is for a pro rata reduction in the cash value, not a reduction of the full amount.

(b) Alternatively, the payment of accelerated benefits can be considered a non-interest bearing lien against the death benefit of the policy or rider and the access to the cash value shall be restricted to any excess of the cash value over the sum of other outstanding loans and the lien. If the lien approach is used, any accelerated death benefit payments shall first be applied toward repaying the portion of any other outstanding policy loans which would cause the sum of the accelerated death benefit and policy loans to exceed the cash value. Future access to the cash values and to policy loans would be limited to the difference between the cash value and the sum of the lien and any other outstanding policy loans.

(c) In either case, the death benefit may not be reduced more than the amount of the accelerated benefits paid plus any applicable actuarial discount appropriate to the policy design for policies without additional premium payments. The accidental death benefit, if any, in the policy or rider shall not be affected by the payment of the accelerated benefit.

HISTORY: Laws, 1991, ch. 464, § 9, eff from and after July 1, 1991.

§ 83-7-119. Filing valuation method and assumptions with Department of Insurance; content.

At the time of filing of the policy form, the valuation method and assumptions need to be filed with the Department of Insurance. The assumptions should reflect the statutory mortality and interest rate assumptions for life insurance policies and appropriate assumptions for the other provisions incorporated in the policy form.

HISTORY: Laws, 1991, ch. 464, § 10, eff from and after July 1, 1991.

VIATICAL SETTLEMENTS

Sec.

83-7-201. Short title.
83-7-203. Definitions.
83-7-205. Viatical settlement providers, representatives and brokers to be licensed by Commissioner of Insurance; licensing requirements.
83-7-207. Suspension, revocation, and refusal to renew license; hearing.
83-7-209. Settlement application, contract and disclosure statement forms to be filed with and approved by Commissioner of Insurance.
83-7-211. Annual statement to be filed with Commissioner; identity of viator not to be disclosed except under certain conditions.
83-7-213. Examination of records, books, files and other information; provider to maintain records of each settlement until 5 years after death of insured.
83-7-215. Disclosure requirements.
83-7-217. Informed consent; confidentiality of medical information; 15-day right to rescind; death of insured within 15-day period deemed rescission; transfer of proceeds of viatical settlement; post-settlement contacts with insured for purpose of determining health status.
83-7-219. Authority of Commissioner to adopt rules and regulations.
83-7-221. Violations of provisions considered unfair trade practice.
83-7-223. Continuation of viatical settlement business pending approval or disapproval of license application filed on or before July 1, 2000.

§ 83-7-201. Short title.

Sections 83-7-201 through 83-7-223 shall be known and may be cited as the "Viatical Settlements Act."

HISTORY: Laws, 2000, ch. 323, § 1, eff from and after July 1, 2000.

Cross References — Viatical settlement investment contracts classified and regulated as securities, see § 75-71-105.

RESEARCH REFERENCES

Practice References.

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-7-203. Definitions.

The following words and phrases shall have the meanings ascribed herein unless the context clearly requires otherwise:

(a) "Person" means a legal entity including, but not limited to, an individual, partnership, limited liability company, association, trust, corporation or other legal entity.

(b) "Viatical settlement representative" means a person who is a licensed agent and acts or aids in any manner in the solicitation of a viatical settlement and who is deemed to represent only the viatical settlement provider. Viatical settlement representative shall not include:

(i) An attorney, an accountant, a financial planner or any person exercising a power of attorney granted by a viator; or

(ii) Any person who is retained to represent a viator and whose compensation is paid by or at the direction of the viator regardless of whether the viatical settlement is consummated.

(c) "Viatical settlement broker" means a licensed agent who acts on behalf of a viator and for a fee, commission or other valuable consideration offers or attempts to negotiate viatical settlements between a viator and one or more viatical settlement providers. Irrespective of the manner in which the viatical settlement broker is compensated, a viatical settlement broker is deemed to represent only the viator and owes a fiduciary duty to the viator to act according to the viator's instructions and in the best interest of the viator. The term does not include an attorney, accountant or financial planner retained to represent the viator whose compensation is paid directly by or at the direction of the viator and who is paid regardless of whether or not the viatical settlement is consummated.

(d) "Viatical settlement contract" means a written agreement entered into between a viatical settlement provider and a viator that establishes the terms under which the viatical settlement provider shall pay compensation or anything of value, which compensation or value is less than the expected death benefit of the insurance policy or certificate, in return for the viator's assignment, transfer, sale, devise or bequest of the death benefit or ownership of all or a portion of the insurance policy or certificate of insurance to the viatical settlement provider. A viatical settlement contract also includes a contract for a loan or other financial transaction secured primarily by an individual or group life insurance policy, other than a loan by a life insurance company pursuant to the terms of the life insurance contract, or a loan secured by the cash value of a policy.

(e) "Viatical settlement provider" means a person, other than a viator, that enters into a viatical settlement contract. Viatical settlement provider also means a person that obtains financing for the purchase, acquisition, transfer or other assignment of one or more viatical settlement contracts, viaticated policies or interests therein or otherwise sells, assigns, transfers, pledges, hypothecates or otherwise disposes of one or more viatical settlement contracts, viaticated policies or interests therein. Viatical settlement provider does not include:

(i) A bank, savings bank, savings and loan association, credit union or other licensed lending institution that takes an assignment of a life insurance policy as collateral for a loan;

(ii) The issuer of a life insurance policy providing accelerated benefits under Sections 83-7-101 through 83-7-117 and pursuant to the contract; or

(iii) A natural person who enters into no more than one (1) agreement in a calendar year for the transfer of life insurance policies for any value less than the expected death benefit.

(f) "Viator" means the owner of a life insurance policy or a certificate holder under a group policy insuring the life of an individual who enters or seeks to enter into a viatical settlement contract.

(g) "Viaticated policy" means a life insurance policy or certificate that has been acquired by a viatical settlement provider pursuant to a viatical settlement contract.

(h) "Commissioner" means the Commissioner of Insurance.

HISTORY: Laws, 2000, ch. 323, § 2, eff from and after July 1, 2000.

§ 83-7-205. Viatical settlement providers, representatives and brokers to be licensed by Commissioner of Insurance; licensing requirements.

(1) A person shall not operate as a viatical settlement provider, viatical settlement representative or viatical settlement broker without first having obtained a license from the commissioner.

(2) Application for a viatical settlement representative or viatical settlement broker license shall be made to the commissioner by the applicant on a form prescribed by the commissioner, and these applications shall be accompanied by a fee of Fifty Dollars ($50.00).

(3) Application for a viatical settlement provider license shall be made to the commissioner by the applicant on a form prescribed by the commissioner. All applications shall be accompanied by a fee of Two Hundred Dollars ($200.00).

(4) Licenses may be renewed from year to year on January 1 upon payment of the annual renewal fees which shall be the same as the application fees. Failure to pay the fees by the renewal date results in expiration of the license.

(5) If an applicant attempting to obtain a license to become a viatical settlement representative or a viatical settlement broker has not been previously licensed within the last two (2) years to sell life insurance, the commissioner shall, as a test of the applicant's knowledge and other qualifications provided herein, require that the applicant submit to a written examination approved by the commissioner.

(6) The applicant shall provide information on forms required by the commissioner. The commissioner shall have authority, at any time, to require the applicant to fully disclose the identity of all stockholders, partners, officers, members and employees, and the commissioner may, in the exercise of the

commissioner's discretion, refuse to issue a license in the name of a legal entity if not satisfied that any officer, employee, stockholder, partner or member thereof who may materially influence the applicant's conduct meets the standards of Sections 83-7-201 through 83-7-223.

(7) Upon the filing of an application and the payment of the license fee, the commissioner shall issue a license if the commissioner finds that the applicant:

(a) Has provided a detailed plan of operation;

(b) Is competent and trustworthy and intends to act in good faith in the capacity involved by the license applied for;

(c) Has a good business reputation and has had experience, training or education so as to be qualified in the business for which the license is applied for; and

(d) If a legal entity, provides a certificate of good standing from the state of its domicile.

(8) The commissioner shall not issue a license to a nonresident applicant, unless a written designation of an agent for service of process is filed and maintained with the commissioner or the applicant has filed with the commissioner the applicant's written irrevocable consent that any action against the applicant may be begun against the applicant by service of process on the commissioner.

HISTORY: Laws, 2000, ch. 323, § 3, eff from and after July 1, 2000.

§ 83-7-207. Suspension, revocation, and refusal to renew license; hearing.

(1) The commissioner may suspend, revoke or refuse to renew the license of a viatical settlement provider, viatical settlement representative or viatical settlement broker if the commissioner finds that:

(a) There was any material misrepresentation in the application for the license;

(b) The licensee or any officer, partner or key management personnel has been convicted of fraudulent or dishonest practices, is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent;

(c) The viatical settlement provider demonstrates a pattern of unreasonable payments to viators;

(d) The licensee has been found guilty of, or has pleaded guilty or nolo contendere to, any felony or to a misdemeanor involving fraud or moral turpitude, regardless of whether a judgment of conviction has been entered by the court;

(e) The viatical settlement provider has failed to honor contractual obligations set out in a viatical settlement contract;

(f) The licensee no longer meets the requirements for initial licensure;

(g) The viatical settlement provider has assigned, transferred or pledged a viaticated policy to a person other than a viatical settlement provider licensed in this state or a financing entity; or

(h) The licensee has violated any provision of Sections 83-7-201 through 83-7-223.

(2) Before the commissioner shall deny a license application or suspend, revoke or refuse to renew the license of a viatical settlement provider, viatical settlement broker or viatical settlement representative, the commissioner shall conduct a hearing in accordance with Section 25-43-1.101 et seq.

HISTORY: Laws, 2000, ch. 323, § 4, eff from and after July 1, 2000.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected typographical errors in (1) (c), (d), (e), and (f). The word "The" was added at the beginning of each paragraph. The Joint Committee ratified the corrections at its May 16, 2002, meeting.

Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section 25-43-1.101" for "Section 25-43-1" at the end of (2). The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-7-209. Settlement application, contract and disclosure statement forms to be filed with and approved by Commissioner of Insurance.

A person shall not provide a viator a viatical settlement application, contract or disclosure statement form in this state unless it has been filed with and approved by the commissioner. The commissioner shall disapprove a viatical settlement application, contract or disclosure statement form if, in the commissioner's opinion, the contract or provisions contained therein are unreasonable, contrary to the interests of the public or otherwise misleading or unfair to the viator.

HISTORY: Laws, 2000, ch. 323, § 5, eff from and after July 1, 2000.

§ 83-7-211. Annual statement to be filed with Commissioner; identity of viator not to be disclosed except under certain conditions.

(1) Each viatical settlement provider issued a license under Sections 83-7-201 through 83-7-223 shall file with the commissioner on or before March 1 of each year an annual statement containing such information as the commissioner by rule may prescribe.

(2) Except as otherwise allowed or required by law, a viatical settlement provider, viatical settlement representative, viatical settlement broker, insurance company, insurance agent, insurance broker, information bureau, rating agency or company, or any other person with actual knowledge of a viator's identity, shall not disclose that identity as a viator to any other person unless the disclosure:

(a) Is necessary to effect a viatical settlement between the viator and a viatical settlement provider and the viator has provided prior written consent to the disclosure;

(b) Is provided in response to an investigation by the commissioner or any other governmental officer or agency; or

(c) Is a term of or condition to the transfer of a viaticated policy by one viatical settlement provider to another viatical settlement provider.

HISTORY: Laws, 2000, ch. 323, § 6, eff from and after July 1, 2000.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in subsection (2)(b). The words "provided in response" were changed to "Is provided in response." The Joint Committee ratified the correction at its May 16, 2002, meeting.

§ 83-7-213. Examination of records, books, files and other information; provider to maintain records of each settlement until 5 years after death of insured.

(1) The commissioner, when the commissioner deems it reasonably necessary to protect the interests of the public, may examine the business and affairs of any licensee or applicant for a license. The commissioner may order any licensee or applicant to produce any records, books, files or other information reasonably necessary to ascertain whether or not the licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The expenses incurred in conducting any examination shall be paid by the licensee or applicant.

(2) Names and individual identification data for all viators shall be considered private and confidential information and shall not be disclosed by the commissioner unless required by law.

(3) Records of all transactions of viatical settlement contracts shall be maintained by the viatical settlement provider and shall be available to the commissioner for inspection during reasonable business hours. A viatical settlement provider shall maintain records of each viatical settlement until five (5) years after the death of the insured.

HISTORY: Laws, 2000, ch. 323, § 7, eff from and after July 1, 2000.

§ 83-7-215. Disclosure requirements.

(1) A viatical settlement provider, viatical settlement representative or viatical settlement broker shall disclose the following information to the viator no later than the time of application:

(a) That possible alternatives exist to viatical settlement contracts for individuals with catastrophic, life threatening or chronic illnesses including any accelerated death benefits offered under the viator's life insurance policy;

(b) That some or all of the proceeds of the viatical settlement may be free from federal income tax and from state franchise and income taxes, and that assistance should be sought from a professional tax advisor;

(c) That proceeds of the viatical settlement could be subject to the claims of creditors;

(d) That receipt of the proceeds of a viatical settlement may adversely effect the viator's eligibility for Medicaid or other government benefits or entitlements, and that advice should be obtained from the appropriate government agencies;

(e) That the viator has the right to rescind a viatical settlement contract fifteen (15) calendar days after the receipt of the viatical settlement proceeds by the viator, as provided in Section 83-7-217(3);

(f) That funds shall be sent to the viator within two (2) business days after the viatical settlement provider has received the insurer or group administrator's acknowledgment that ownership of the policy or interest in the certificate has been transferred and that the beneficiary has been designated pursuant to the viatical settlement contract; and

(g) That entering into a viatical settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate, to be forfeited by the viator and that assistance should be sought from a financial adviser.

(2) A viatical settlement provider shall disclose the following information to the viator before the date the viatical settlement contract is signed by all parties:

(a) The affiliation, if any, that exist between the viatical settlement provider and the issuer of an insurance policy to be viaticated;

(b) If an insurance policy to be viaticated has been issued as a joint policy or involves family riders or any coverage of a life other than the insured under the policy to be viaticated, the viator shall be informed of the possible loss of coverage on the other lives and shall be advised to consult with his or her insurance producer or the company issuing the policy for advice on the proposed viatication; and

(c) The dollar amount of the current death benefit that is payable to the viatical settlement provider under the policy or certificate. The viatical settlement provider shall also disclose the availability of any additional guaranteed insurance benefits, the dollar amount of any accidental death and dismemberment benefits under the policy or certificate and the viatical settlement provider's interest in those benefits.

(3) A viatical settlement provider shall maintain at its home or principal office a copy of every printed, published or prepared advertisement or "invitation to inquire" including any electronic advertising it has used in this state for at least three (3) years. Providers shall also maintain all advertising for any affiliate, associated person, controlling person, broker or agent including independent contracts and escrow agents. Each advertisement or "invitation to inquire" shall contain a notation clearly stating the name of the individual authorizing the advertisement, the dates the advertisements were printed or published and the manner and extent of distribution of each advertisement. A file containing the information set forth in this section shall be available for inspection by the commissioner.

HISTORY: Laws, 2000, ch. 323, § 8, eff from and after July 1, 2000.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected typographical errors in subsections (1)(d), (1)(e), and (2). The word "That" was added at the beginning of subsections (1)(d) and (1)(e). The word "A" was added at the beginning of subsection (2). The Joint Committee ratified the corrections at its May 16, 2002 meeting.

§ 83-7-217. Informed consent; confidentiality of medical information; 15-day right to rescind; death of insured within 15-day period deemed rescission; transfer of proceeds of viatical settlement; post-settlement contacts with insured for purpose of determining health status.

(1) Before the viatical settlement provider enters into a viatical settlement contract, the provider shall obtain:

(a) If the viator is the insured, a written statement from a licensed attending physician that the viator is of sound mind;

(b) A witnessed document in which the viator consents to the viatical settlement contract, represents that the viator has a full and complete understanding of the viatical settlement contract, that he or she has a full and complete understanding of the benefits of the life insurance policy and acknowledges that he or she has entered into the viatical settlement contract freely and voluntarily; and

(c) A document in which the insured consents to the release of his or her medical records to a viatical settlement provider or viatical settlement broker.

(2) All medical information solicited or obtained by any licensee shall be subject to the applicable provision of state law relating to confidentiality of medical information.

(3) All viatical settlement contracts entered into in this state shall provide the viator with an unconditional right to rescind the contract for at least fifteen (15) calendar days from the receipt of the viatical settlement proceeds. If the insured dies during the rescission period, the viatical settlement contract shall be deemed to have been rescinded, subject to repayment to the viatical settlement provider of all viatical settlement proceeds.

(4) Immediately upon the viatical settlement provider's receipt of documents to effect the transfer of the insurance policy, the viatical settlement provider shall pay the proceeds of the viatical settlement to an escrow or trust account in a state or federally chartered financial institution whose deposits are insured by the Federal Deposit Insurance Corporation (FDIC). The account shall be managed by a trustee or escrow agent independent of the parties to the contract. The trustee or escrow agent shall transfer the proceeds to the viator immediately upon the viatical settlement provider's receipt of acknowledgment of the transfer of the insurance policy.

(5) Failure to tender consideration to the viator for the viatical settlement contract within the time disclosed under Section 83-7-215(1)(f) renders the

viatical settlement contract voidable by the viator for lack of consideration until the time consideration is tendered to and accepted by the viator.

(6) Contacts with the insured for the purpose of determining the health status of the insured by the viatical settlement provider, viatical settlement broker or viatical settlement representative after the viatical settlement has occurred shall be made only by the viatical settlement provider or broker licensed in this state and shall be limited to once every three (3) months for insureds with a life expectancy of more than one (1) year, and to no more than one (1) per month for insureds with a life expectancy of one (1) year or less. The viatical settlement representative or broker shall explain the procedure for these contacts at the time the viatical settlement contract is entered into and shall obtain a statement signed by the viator stating that the viator understands these procedures. The limitations set forth in this subsection shall not apply to any contacts with an insured under a viaticated policy for reasons other than determining the insured's health status.

HISTORY: Laws, 2000, ch. 323, § 9, eff from and after July 1, 2000.

§ 83-7-219. Authority of Commissioner to adopt rules and regulations.

The commissioner may:

(a) Promulgate rules and regulations implementing Sections 83-7-201 through 83-7-223;

(b) Establish standards for evaluating reasonableness of payments under viatical settlement contracts. This authority includes, but is not limited to, regulation of discount rates used to determine the amount paid in exchange for assignment, transfer, sale, devise or bequest of a benefit under a life insurance policy;

(c) Establish appropriate licensing requirements, fees and standards for continued licensure for viatical settlement providers, representatives and brokers;

(d) Require a bond or other mechanism for financial accountability for viatical settlement providers; and

(e) Adopt rules governing the relationship and responsibilities of both insurers and viatical settlement providers, brokers and representatives during the viatication of a life insurance policy or certificate.

HISTORY: Laws, 2000, ch. 323, § 10, eff from and after July 1, 2000.

§ 83-7-221. Violations of provisions considered unfair trade practice.

A violation of Sections 83-7-201 through 83-7-223 shall be considered an unfair trade practice under Section 83-5-29 et seq. and the violator is subject to the penalties therein.

HISTORY: Laws, 2000, ch. 323, § 11, eff from and after July 1, 2000.

§ 83-7-223. Continuation of viatical settlement business pending approval or disapproval of license application filed on or before July 1, 2000.

A viatical settlement provider, viatical settlement representative or viatical settlement broker transacting business in this state may continue to do so pending approval or disapproval of the provider's, representative's or broker's application for a license if the application is filed with the commissioner by July 1, 2000.

HISTORY: Laws, 2000, ch. 323, § 13, eff from and after July 1, 2000.

UNCLAIMED LIFE INSURANCE BENEFITS ACT

Sec.	
83-7-301.	Short title.
83-7-303.	Purpose.
83-7-305.	Definitions.
83-7-307.	Insurer conduct.
83-7-309.	Insurer unclaimed property reporting.
83-7-311.	Limitation on promulgation of rules or regulations that impose additional duties on insurers beyond those set out in Sections 83-7-301 through 83-7-313.
83-7-313.	Effect of certain agreements between insurers and Commissioner of Insurance or State Treasurer.

§ 83-7-301. Short title.

Sections 83-7-301 through 83-7-313 shall be known as the "Unclaimed Life Insurance Benefits Act."

HISTORY: Laws, 2014, ch. 431, § 1, eff from and after July 1, 2015.

§ 83-7-303. Purpose.

Sections 83-7-301 through 83-7-313 confirm the applicability of the escheat and unclaimed property statutes of Mississippi to any method of payment for life insurance death benefits regulated by the Mississippi Department of Insurance, and establish the sole standards by which such escheat and unclaimed property statutes are applicable to such payments.

HISTORY: Laws, 2014, ch. 431, § 2, eff from and after July 1, 2015.

§ 83-7-305. Definitions.

As used in Sections 83-7-301 through 83-7-313:

(a) "Account owner" means the owner of a retained asset account who is a resident of this state.

(b) "Annuity" means an annuity contract issued in this state. The term "annuity" shall not include any annuity contract used to fund an employment-based retirement plan or program where the insurer takes direction from the plan sponsor and plan administrator.

(c) "Death master file" means the United States Social Security Administration's Death Master File or any other database or service that is at least as comprehensive as the United States Social Security Administration's Death Master File for determining that a person has reportedly died.

(d) "Death master file match" means a search of the death master file that results in a match of a person's name and social security number, or the name and date of birth.

(e) "Insurer" means a life insurance company as defined in Section 83-7-1.

(f) "Knowledge of death" shall, for purposes of Sections 83-7-301 through 83-7-313, for purposes of Section 83-7-6, and for purposes of establishing the presumption of abandonment of funds held or owing by a life insurance corporation under Section 89-12-7 mean (i) receipt of an original or valid copy of a certified death certificate, or (ii) a death master file match validated by a secondary source by the insurer.

(g) "Person" means the policy owner, insured, annuity owner, annuitant or account owner, as applicable under the policy, annuity, or retained asset account subject to Sections 83-7-301 through 83-7-313.

(h) "Policy" means any policy or certificate of life insurance issued in this state; except the term "policy" shall not include (i) any policy or certificate of life insurance that provides a death benefit under an employee benefit plan subject to The Employee Retirement Income Security Act of 1974 [29 USC 1002], as periodically amended, or under any federal employee benefit program, (ii) any policy or certificate of life insurance that is used to fund a preneed funeral contract or prearrangement, (iii) any policy or certificate of credit life or accidental death insurance, (iv) any policy or certificate of industrial life insurance, or (v) any policy issued to a group master policyholder for which the insurer does not provide record keeping services.

(i) "Record keeping services" means those circumstances under which the insurer has agreed with a group policyholder to be responsible for obtaining, maintaining and administering in its own systems information about each individual insured under an insured's group insurance contract (or a line of coverage thereunder), at least the following information: (i) social security number or name and date of birth, (ii) beneficiary designation information, (iii) coverage eligibility, (iv) benefit amount, and (v) premium payment status.

HISTORY: Laws, 2014, ch. 431, § 3, eff from and after July 1, 2015.

§ 83-7-307. Insurer conduct.

(1) An insurer shall perform a comparison of its in-force policies, annuities and retained asset accounts issued in this state against a death master

file, on at least a semiannual basis, to identify potential death master file matches.

(a) An insurer may comply with the requirements of this section by using the full death master file once annually and using the death master file update files for the remaining comparisons in that year.

(b) Nothing in this section shall limit the insurer from requesting a valid death certificate as part of any claims validation process.

(2) If an insurer obtains knowledge of the death of a person, then the insurer shall within ninety (90) days:

(a) Complete a good-faith effort, which shall be documented by the insurer, to confirm the death of the person against other available records and information;

(b) Review its records to determine whether the deceased person had purchased any other products with the insurer;

(c) Determine whether benefits may be due in accordance with any applicable policy, annuity or retained asset account issued or assumed by the insurer; and

(d) If the beneficiary or other authorized representative has not communicated with the insurer within the ninety-day period, take reasonable steps, which shall be documented by the insurer, to locate and contact the beneficiary or beneficiaries or other authorized representative on any such policy, annuity or retained asset account, including, but not limited to, sending the beneficiary information regarding the insurer's claims process, including the need to provide an official death certificate if applicable under the policy, annuity or retained asset account.

(e) In the event the insurer is unable to confirm the death of a person following a death master file match, an insurer may consider such policy, annuity or retained asset account to be in force in accordance with its terms.

(3) An insurer shall not be required to do the comparison under this section or take the steps described in this section with respect to policies, annuities or retained asset accounts issued and delivered prior to July 1, 2015.

(4) To the extent permitted by law, an insurer may disclose minimum necessary personal information about a person or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer in locating the beneficiary or a person otherwise entitled to payment of the policy, annuity or retained asset account proceeds.

(5) An insurer or its service provider shall not charge any beneficiary or other authorized representative for any fees or costs associated with a death master file search or verification of a death master file match conducted pursuant to this section.

(6) The benefits from a policy, annuity or retained asset account, plus any applicable accrued contractual interest shall first be payable to the designated beneficiaries or owners and in the event said beneficiaries or owners cannot be found, shall escheat to the state as unclaimed property pursuant to Section 89-12-7. Interest payable under Section 83-7-6 shall not be payable as unclaimed property under Section 89-12-7(1) or (3).

(7) The Commissioner of Insurance shall have exclusive authority and jurisdiction on behalf of the State Treasurer to examine the records of insurers to determine if they have complied with the Mississippi escheat and unclaimed property laws, and may adopt such rules and regulations as may be reasonably necessary to implement the provisions of Sections 83-7-301 through 83-7-313.

(8) The Commissioner of Insurance may, in his or her reasonable discretion, make an order:

(a) Limiting an insurer's death master file comparisons required under subsection (1) to the insurer's electronic searchable files or approving a plan and timeline for conversion of the insurer's files to electronic searchable files;

(b) Exempting an insurer from the death master file comparisons required under subsection (1) or permitting an insurer to perform such comparisons less frequently than semiannually upon a demonstration of financial hardship by the insurer; or

(c) Phasing-in compliance with this section according to a plan and timeline approved by the Commissioner of Insurance.

(9) A violation of Sections 83-7-301 through 83-7-313 shall be subject to the penalty provisions set forth in Section 83-5-17, as well as other penalty provisions under applicable law. Nothing herein shall be construed to create or imply a private cause of action for a violation of Sections 83-7-301 through 83-7-313.

HISTORY: Laws, 2014, ch. 431, § 4, eff from and after July 1, 2015.

§ 83-7-309. Insurer unclaimed property reporting.

In the event that an insurer: (a) has identified a person as deceased through a death master file match through a search described in Section 83-7-307(1) or other information source, (b) has validated such information through a secondary information source, and (c) is unable to locate a beneficiary under the policy, annuity or retained asset account after conducting reasonable search efforts during the period of up to one (1) year after the insurer's validation of the death master file match, or if no beneficiary, if the person, as applicable for unclaimed reporting purposes, has a last-known address in this state, then the insurer is authorized to report and remit the proceeds of such policy, annuity or retained asset account due to the state on an early reporting basis, without further notice or consent by the state, after attempting to contact such beneficiary pursuant to Section 89-12-7. Once reported and proceeds are remitted, the insurer shall be relieved and indemnified from any and all additional liability to any person relating to the proceeds reported and remitted, including, but not limited to, any liability under for all proceeds reported and remitted to the state pursuant to Sections 83-7-301 through 83-7-313. This indemnification from liability shall be in addition to any other protections provided by law. Any proceeds remitted to the state pursuant to Sections 83-7-301 through 83-7-313 shall be deposited in the Abandoned Property Fund maintained by the State Treasurer.

HISTORY: Laws, 2014, ch. 431, § 5, eff from and after July 1, 2015.

§ 83-7-311. Limitation on promulgation of rules or regulations that impose additional duties on insurers beyond those set out in Sections 83-7-301 through 83-7-313.

Neither the Commissioner of Insurance nor the State Treasurer shall promulgate rules, regulations or issue bulletins that impose, or interpret Sections 83-7-301 through 83-7-313 to impose, additional duties and obligations on insurers beyond those set forth in Sections 83-7-301 through 83-7-313, or otherwise attempt to expand the requirements of Sections 83-7-301 through 83-7-313.

HISTORY: Laws, 2014, ch. 431, § 6, eff from and after July 1, 2015.

§ 83-7-313. Effect of certain agreements between insurers and Commissioner of Insurance or State Treasurer.

In the event that any resolution agreement, regulatory settlement agreement, or a voluntary disclosure agreement between an insurer who has used the death master file to terminate annuity payments but not to locate life beneficiaries and the Commissioner of Insurance or the State Treasurer conflicts with Sections 83-7-301 through 83-7-313, the terms of the agreement shall supersede Sections 83-7-301 through 83-7-313.

HISTORY: Laws, 2014, ch. 431, § 7, eff from and after July 1, 2015.

CHAPTER 9.

ACCIDENT, HEALTH AND MEDICARE SUPPLEMENT INSURANCE

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ACCIDENT AND HEALTH INSURANCE

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83-9-21. Judicial review.
83-9-22. Health coverage plans prohibited from restricting coverage for medically appropriate treatment prescribed by physician based on insured's diagnosis with terminal condition.
83-9-23. Health and accident insurance for resident senior citizens.
83-9-24. Prohibition against requiring higher co-payment, coinsurance, etc., for patient-administered anti-cancer medications than is required for anti-cancer medications injected or intravenously administered by health care provider.

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83-9-25. Examination and return of policy.
83-9-26. Screening, diagnosis and treatment of autism spectrum disorder.
83-9-27. Alcoholism care and treatment; coverage.
83-9-29. Alcoholism care and treatment; application of law.
83-9-31. Alcoholism care and treatment; limitation of coverage.
83-9-32. Coverage for medical benefits when dental care provided under physician-supervised anesthesia.
83-9-33. Coverage for newly born children.
83-9-34. Child immunizations; optional coverage; written acceptance or rejection; application of section.
83-9-35. Replacement of group or blanket health and accident policy or plan; succeeding carrier's plan to continue certain benefits and provisions.
83-9-36. Process by which prescribing practitioner may request override of restriction on medication restricted for use by insurer step therapy or fail-first protocol; circumstances under which insurer to grant override.

§ 83-9-1. Definition of accident and sickness insurance policy.

The term "policy of accident and sickness insurance," as used in Sections 83-9-1 through 83-9-21, includes any individual or group policy or contract of insurance against loss resulting from sickness or from bodily injury, including dental care expenses resulting from sickness or bodily injury, or death by accident, or accidental means, or both.

HISTORY: Codes, 1942, § 5687-01; Laws, 1956, ch. 330, § 1; Laws, 1989, ch. 466, § 2, eff from and after July 1, 1989.

Cross References — Registration and examination of companies writing health and accident insurance, see §§ 83-6-1 et seq.

RESEARCH REFERENCES

ALR.

What constitutes permanent or total disability within coverage of insurance policy issued to physical laborer or workman. 32 A.L.R.3d 922.

Validity and construction of accident insurance policy provision making benefits conditional on disability occurring immediately, or at once, or within specified time of accident. 39 A.L.R.3d 1026.

Validity and construction of provision in accident insurance policy limiting coverage for death or loss of member to death or loss occurring within specified period after accident. 39 A.L.R.3d 1311.

Validity and construction of prescription drug insurance plans. 42 A.L.R.3d 897.

Conclusiveness of recitation, in delivered insurance policy, that initial premium has been paid. 44 A.L.R.3d 1361.

Medical Care Insurance: right of insured under individual policy to coverage afforded by group policy from which he directly transferred on termination of his employment. 66 A.L.R.3d 1192.

Death during or allegedly resulting from surgery as accidental or from accidental means within coverage of health or accident insurance policy. 91 A.L.R.3d 1042.

Heart attack following exertion or exercise as within terms of accident provision of insurance policy. 1 A.L.R.4th 1319.

What constitutes total disability within coverage of disability insurance policy issued to lawyer. 6 A.L.R.4th 422.

Accident insurance: death or disability incident to partaking of food or drink as within provision as to external, violent, and accidental means. 29 A.L.R.4th 1230.

Construction and application of provision of liability insurance policy expressly excluding injuries intended or expected by insured. 31 A.L.R.4th 957.

Criminal conviction as rendering conduct for which insured convicted within provision of liability insurance policy expressly excluding coverage for damage or injury intended or expected by insured. 35 A.L.R.4th 1063.

Accident or life insurance: death by autoerotic asphyxiation as accidental. 62 A.L.R.4th 823.

Coverage under medical and health insurance plans for services performed by dentist, oral surgeons, and orthodontists. 43 A.L.R.5th 657.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 5-7, 1210.

44 Am. Jur. 2d, Insurance §§ 1218 et seq.

CJS.

44 C.J.S., Insurance §§ 1-3, 21.

45 C.J.S., Insurance §§ 1092, 1259.

Practice References.

Business Insurance Law and Practice Guide, (Matthew Bender).

Business Law Monographs, Volume IN1 —Business Uses of Life Insurance (Matthew Bender Elite Products).

Business Law Monographs, Volume IN2 —Casualty and Liability Insurance (Matthew Bender).

§ 83-9-3. Form of policy; commissioner's fees; expedited form and rate review procedure; funding of agency expenses; deposit of monies into State General Fund.

(1) No policy of accident and sickness insurance shall be delivered or issued for delivery to any person in this state unless:

(a) The entire money and other considerations therefor are expressed therein; and

(b) The time at which the insurance takes effect and terminates is expressed therein; and

(c) It purports to insure only one (1) person, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who shall be deemed the policyholder, any two (2) or more eligible members of that family, including husband, wife, dependent children or any children under a specified age which shall not exceed nineteen (19) years, and any other person dependent upon the policyholder; and

(d) The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the text, and unless every printed portion of the text of the policy and of any endorsements or attached papers is plainly printed in lightfaced type of a style in general use, the size of which shall be uniform and not less than ten-point with a lowercase unspaced alphabet length not less than one-hundred-twenty-point (the "text" shall include all printed matter except the name and address of the insurer, name or title of the policy, the brief description if any, and captions and subcaptions); and

(e) The exceptions and reductions of indemnity are set forth in the policy and, except those which are set forth in Section 83-9-5, are printed, at the insurer's option, either with the benefit provision to which they apply, or under an appropriate caption such as "Exceptions" or "Exceptions and Reductions," provided that if an exception or reduction specifically applies only to a particular benefit of the policy, a statement of such exception or reduction shall be included with the benefit provision to which it applies; and

(f) Each such form, including riders and endorsements, shall be identified by a form number in the lower left-hand corner of the first page thereof; and

(g) It contains no provision purporting to make any portion of the charter, rules, constitution or bylaws of the insurer a part of the policy unless such portion is set forth in full in the policy, except in the case of the incorporation of, or reference to, a statement of rates or classification of risks, or short-rate table filed with the commissioner.

(2) No individual or group policy covering health and accident insurance (including experience-rated insurance contracts, indemnity contracts, self-insured plans and self-funded plans), or any group combinations of these coverages, shall be issued by any commercial insurer doing business in this state which, by the terms of such policy, limits or excludes payment because the individual or group insured is eligible for or is being provided medical assistance under the Mississippi Medicaid Law. Any such policy provision in violation of this section shall be invalid.

(3) No individual or group policy covering health and accident insurance (including experience-rated insurance contracts, indemnity contracts, self-insured plans and self-funded plans) or any group combinations of these coverages, shall be issued by any commercial insurer doing business in this state, which, by the terms of such policy, limits or restricts the insured's ability to assign the insured's benefits under the policy to a licensed health care provider that provides health care services to the insured. Commercial insurers doing business in this state shall honor an assignment for a period of one (1) year starting from the initial date of an assignment. Any such policy provision in violation of this subsection shall be invalid.

(4) If any policy is issued by an insurer domiciled in this state for delivery to a person residing in another state, and if the official having responsibility for the administration of the insurance laws of such other state shall have advised the commissioner that any such policy is not subject to approval or disapproval by such official, the commissioner may, by ruling, require that such policy meet the standards set forth in subsection (1) of this section and in Section 83-9-5.

(5) The commissioner shall collect and pay into the special fund in the State Treasury designated as the "Insurance Department Fund" the following fees for services provided under this section:

FORM	FEE
Each individual policy contract, including revisions	$15.00
Each group master policy or contract, including revisions	15.00
Each rider, endorsement or amendment, etc	10.00
Each insurance application where written application is required and is to be made a part of the policy or contract	10.00
Each questionnaire	7.00
Charge for resubmission where payment is not included with original submission	5.00

Additional charge for tentative approval same as above.

(6) In order to expedite and become more efficient in reviewing and approving accident and health form and rate filings, the commissioner may establish an expedited form and rate review procedure whereby insurers may elect to pay reasonable actuarial fees directly to a department-approved actuarial service in exchange for an expedited review of form and rate filings by the actuarial service. The commissioner may make such reasonable rules and regulations concerning the expedited procedure, and may set reasonable fees for the actuarial services provided. This provision shall not abridge any other authority granted to the commissioner by law, including the authority to collect the filing fees prescribed by this section.

(7) From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

(8) From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1942, § 5687-02; Laws, 1956, ch. 330, § 2; Laws, 1988, ch. 526, § 4; Laws, 1989, ch. 408, § 1; Laws, 1991, ch. 354 § 1; Laws, 1997, ch. 324, § 3; Laws, 2008, ch. 432, § 2; Laws, 2013, ch. 302, § 1; Laws, 2014, ch. 404, § 1; Laws, 2016, ch. 312, § 1; Laws, 2016, ch. 459, § 28, eff from and after July 1, 2016; brought forward without change, Laws, 2020, ch. 420, § 2, eff from and after July 1, 2020.

Joint Legislative Committee Note — Section 1 of ch. 312 Laws of 2016, effective from and after July 1, 2016 (approved April 4, 2016), amended this section. Section 28 of ch. 459, Laws of 2016, effective from and after July 1, 2016 (approved May 6, 2016), also amended this section. As set out above, this section reflects the language of both amendments pursuant to Section 1-1-109, which gives the Joint Legislative Committee on Compilation, Revision and Publication of Legislation authority to integrate amendments so that all versions of the same code section enacted within the same legislative session may become effective. The Joint Committee on Compilation, Revision and Publication of Legislation ratified the integration of these amendments as consistent with the legislative intent at the August 5, 2016, meeting of the Committee.

Editor's Notes — Section 13 of ch. 526, Laws, 1988, provides as follows:

"SECTION 13. The commissioner may, after notice and hearing, issue rules and regulations that he deems necessary to effectuate the purposes of this act or to eliminate devices or plans designed to avoid or render ineffective the provisions of this act. The commissioner may require such information as is reasonably necessary for the enforcement of this act. All rules and regulations adopted and promulgated pursuant to this act shall be subject to the provisions of the Mississippi Administrative Procedures Law as provided in Section 25-43-1 et seq. [now 25-43-1.101 et seq.], Mississippi Code of 1972."

Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Standards for policy provisions for Medicare supplement insurance policies, see § 83-9-103.

RESEARCH REFERENCES

ALR.

Person to whom renewal premium may be paid or tendered so as to bind insurer. 42 A.L.R.3d 751.

Am. Jur.

43 Am. Jur. 2d, Insurance § 68.

§ 83-9-4. Commissioner may disapprove policy form, amendatory rider or endorsement currently in effect under certain circumstances; procedure; applicability.

(1) The Commissioner of Insurance may disapprove a policy form, amendatory rider or endorsement currently in effect if the commissioner finds that a portion or all of the policy form, amendatory rider or endorsement:

(a) Is in any respect in violation of any state or federal laws; or

(b) Contains or incorporates by reference any inconsistent, ambiguous or misleading clauses or exceptions and conditions.

(2) If the commissioner disapproves a policy form, amendatory rider or endorsement currently in effect, the commissioner shall issue an order only after a hearing held on not less than thirty (30) days written notice to the filing insurer. The insurer may waive the hearing. The commissioner shall issue an order within thirty (30) days after the close of the hearing or within thirty (30) days after the filing of a waiver of hearing and shall specify in what respects the policy form, amendatory rider or endorsement fails to meet the requirements of this section. The commissioner may extend the thirty-day period for issuance of an order for an additional thirty (30) days.

(3) This section may apply to any health insurance policy or employee health benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state, but shall not apply to any policy of disability income insurance or long-term care insurance.

(4) The commissioner may promulgate rules and regulations necessary to carry out the provisions of this section.

HISTORY: Laws, 2014, ch. 405, § 1, eff from and after passage (approved Mar. 19, 2014).

§ 83-9-5. Policy provisions.

(1) **Required provisions.** Except as provided in subsection (3) of this section, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in this subsection in the words in which the same appear in this section. However, the insurer may, at its option, substitute for one or more of such provisions, corresponding provisions of

different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

As used in this section, the term "insurer" means a health maintenance organization, an insurance company or any other entity responsible for the payment of benefits under a policy or contract of accident and sickness insurance; however, the term "insurer" shall not mean a liquidator, rehabilitator, conservator or receiver or third-party administrator of any health maintenance organization, insurance company or other entity responsible for the payment of benefits which is in liquidation, rehabilitation or conservation proceedings, nor shall it mean any responsible guaranty association. Further, no cause of action shall accrue against a liquidator, rehabilitator, conservator or receiver or third-party administrator of any health maintenance organization, insurance company or other entity responsible for the payment of benefits which is in liquidation, rehabilitation or conservation proceedings or any responsible guaranty association under paragraph (h)3 of this subsection or any policy provision in accordance therewith.

(a) A provision as follows:

Entire contract; changes: This policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

(b) A provision as follows:

Time limit on certain defenses:

1. After two (2) years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of such two-year period.

(The foregoing policy provision shall not be so construed as to effect any legal requirement for avoidance of a policy or denial of a claim during such initial two-year period, nor to limit the application of subsection (2)(a) and (2)(b) of this section in the event of misstatement with respect to age or occupation.)

(A policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (1) until at least age fifty (50) or, (2) in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue, may contain in lieu of the foregoing the following provision (from which the clause in parentheses may be omitted at the insurer's option) under the caption "INCONTESTABLE":

After this policy has been in force for a period of two (2) years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements in the application.)

2. No claim for loss incurred or disability (as defined in the policy) commencing after two (2) years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

(c) A provision as follows:

Grace period:

A grace period of seven (7) days for weekly premium policies, ten (10) days for monthly premium policies and thirty-one (31) days for all other policies will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision, "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof."

A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision, "unless not less than five (5) days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted.")

(d) A provision as follows:

Reinstatement:

If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy. However, if the insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the insurer or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten (10) days after such date. In all other respects the insured and insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement. (The last sentence of the above provision may be omitted from any policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty (50) or, (2) in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue.)

(e) A provision as follows:

Notice of claim:

Written notice of claim must be given to the insurer within thirty (30) days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ______________ (insert the location of such office as the insurer may designate for the purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer.

(In a policy providing a loss of time benefit which may be payable for at least two (2) years, an insurer may, at its option, insert the following between the first and second sentences of the above provision: "Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity may be payable for at least two (2) years, he shall, at least once in every six (6) months after having given notice of claim, give to the insurer notice of continuance of said disability, except in the event of legal incapacity. The period of six (6) months following any filing of proof by the insured or any payment by the insurer on account of such claim or any denial of liability, in whole or in part, by the insurer shall be excluded in applying this provision. Delay in the giving of such notice shall not impair the insured's right to any indemnity which would otherwise have accrued during the period of six (6) months preceding the date on which such notice is actually given.")

(f) A provision as follows:

Claim forms:

The insurer, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

(g) A provision as follows:

Proofs of loss:

Written proof of loss must be furnished to the insurer at its said office, in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss, within ninety (90) days after the termination of the period for which the insurer is liable, and in case of claim for any other loss, within ninety (90) days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one (1) year from the time proof is otherwise required.

(h) A provision as follows:

Time of payment of claims:

1. All benefits payable under this policy for any loss, other than loss for which this policy provides any periodic payment, will be paid within twenty-five (25) days after receipt of due written proof of such loss in the form of a clean claim where claims are submitted electronically, and will be paid within thirty-five (35) days after receipt of due written proof of such loss in the form of clean claim where claims are submitted in paper format. Benefits due under the policies and claims are overdue if not paid within twenty-five (25) days or thirty-five (35) days, whichever is applicable, after the insurer receives a clean claim containing necessary medical information and other information essential for the insurer to administer preexisting condition, coordination of benefits and subrogation provisions. A "clean claim" means a claim received by an insurer for adjudication and which requires no further information, adjustment or alteration by the provider of the services or the insured in order to be processed and paid by the insurer. A claim is clean if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under this provision. A clean claim includes resubmitted claims with previously identified deficiencies corrected. Errors, such as system errors, attributable to the insurer, do not change the clean claim status.

A clean claim does not include any of the following:

a. A duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim;

b. Claims which are submitted fraudulently or that are based upon material misrepresentations;

c. Claims that require information essential for the insurer to administer preexisting condition, coordination of benefits or subrogation provisions; or

d. Claims submitted by a provider more than thirty (30) days after the date of service; if the provider does not submit the claim on behalf of the insured, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the provider to the insured.

Not later than twenty-five (25) days after the date the insurer actually receives an electronic claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Not later than thirty-five (35) days after the date the insurer actually receives a paper claim, the insurer shall pay the appropriate benefit in full, or any portion of the claim that is clean, and notify the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) of the reasons why the claim or portion thereof is not clean and will not be paid and what substantiating documentation and information is required to adjudicate the claim as clean. Any claim or portion thereof resubmitted with the supporting documentation and information requested by the insurer shall be paid within twenty (20) days after receipt.

For purposes of this provision, the term "pay" means that the insurer shall either send cash or a cash equivalent by United States mail, or send cash or a cash equivalent by other means such as electronic transfer, in full satisfaction of the appropriate benefit due the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured). To calculate the extent to which any benefits are overdue, payment shall be treated as made on the date a draft or other valid instrument was placed in the United States mail to the last known address of the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) in a properly addressed, postpaid envelope, or, if not so posted, or not sent by United States mail, on the date of delivery of payment to the provider or insured.

2. Subject to due written proof of loss, all accrued benefits for loss for which this policy provides periodic payment will be paid ______________ (insert period for payment which must not be less frequently than monthly), and any balance remaining unpaid upon the termination of liability will be paid within thirty (30) days after receipt of due written proof.

3. If the claim is not denied for valid and proper reasons by the end of the applicable time period prescribed in this provision, the insurer must pay the provider (where the claim is owed to the provider) or the insured (where the claim is owed to the insured) interest on accrued benefits at the rate of three percent (3%) per month accruing from the day after payment was due on the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated. Whenever interest due pursuant to this provision is less than One Dollar ($1.00), such amount shall be credited to the account of the person or entity to whom such amount is owed. The provisions of this subparagraph 3 shall not apply to any claims or benefits owed under Medicare Advantage plans or Medicare Advantage Prescription Drug plans.

4. In the event the insurer fails to pay benefits when due, the person entitled to such benefits may bring action to recover such

benefits, any interest which may accrue as provided in subparagraph 3 of this paragraph (h) and any other damages as may be allowable by law. If it is determined in such action that the insurer acted in bad faith as evidenced by a repeated or deliberate pattern of failing to pay benefits and/or claims when due, the person entitled to such benefits (health care provider or insured) shall be entitled to recover damages in an amount up to three (3) times the amount of the benefits that remain unpaid until the claim is finally settled or adjudicated.

(i) A provision as follows:

Payment of claims:

Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the insured. Any other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the insured. When payments of benefits are made to an insured directly for medical care or services rendered by a health care provider, the health care provider shall be notified of such payment. The notification requirement shall not apply to a fixed-indemnity policy, a limited benefit health insurance policy, medical payment coverage or personal injury protection coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance or workers' compensation. If the insured provides the insurer with written direction that all or a portion of any indemnities or benefits provided by the policy be paid to a licensed health care provider rendering hospital, nursing, medical or surgical services, then the insurer shall pay directly the licensed health care provider rendering such services. That payment shall be considered payment in full to the provider, who may not bill or collect from the insured any amount above that payment, other than the deductible, coinsurance, copayment or other charges for equipment or services requested by the insured that are noncovered benefits. Any dispute between a provider and the insured arising under these provisions regarding assignment of benefits and billing may be resolved by the Commissioner of Insurance. The Commissioner of Insurance shall adopt any rules and regulations necessary to enforce these provisions regarding assignment of benefits and billing.

(The following provision may be included with the foregoing provision at the option of the insurer: "If any indemnity of this policy shall be payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity, up to an amount not exceeding $\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (insert an amount which must not exceed One Thousand Dollars ($1,000.00)), to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.")

(j) A provision as follows:

Physical examinations:

The insurer at his own expense shall have the right and opportunity to examine the person of the insured when and as often as it may reasonably require during the pendency of a claim hereunder.

(k) A provision as follows:

Legal actions:

No action at law or in equity shall be brought to recover on this policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

(*l*) A provision as follows:

Change of beneficiary:

Unless the insured makes an irrevocable designation of beneficiary, the right to change the beneficiary is reserved to the insured, and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy, or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

(The first clause of this provision, relating to the irrevocable designation of beneficiary, may be omitted at the insurer's option.)

(2) **Other provisions.** Except as provided in subsection (3) of this section, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section. However, the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(a) A provision as follows:

Change of occupation:

If the insured be injured or contract sickness after having changed his occupation to one classified by the insurer as more hazardous than that stated in this policy or while doing for compensation anything pertaining to an occupation so classified, the insurer will pay only such portion of the indemnities provided in this policy as the premium paid would have purchased at the rates and within the limits fixed by the insurer for such more hazardous occupation. If the insured changes his occupation to one classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of such change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of such proof, whichever is the most recent. In applying this provision, the classification of occupational risk and the premium rates shall be such as have been last filed by the insurer prior to the occurrence of the loss for which the insurer is liable, or prior to date of proof of change in occupation, with the state official having supervision of insurance in the state where the insured resided at the time this policy was issued; but if such filing was not required, then the classification of occupational risk and the premium rates shall be those last made effective by the insurer in such state prior to the occurrence of the loss or prior to the date of proof of change in occupation.

(b) A provision as follows:

Misstatement of age:

If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

(c) A provision as follows:

Relation of earnings to issuance:

If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of two (2) years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such two (2) years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of Two Hundred Dollars ($200.00) or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time.

(The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age fifty (50) or, (2) in the case of a policy issued after age forty-four (44), for at least five (5) years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage," approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulations by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner, or any combination of such coverages. In the absence of such definition, such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workers' compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

(d) A provision as follows:

Unpaid premium:

Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

(e) A provision as follows:

Cancellation:

The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five (5) days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term, the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

(f) A provision as follows:

Conformity with state statutes:

Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

(g) A provision as follows:

Illegal occupation:

The insurer shall not be liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

(h) A provision as follows:

Intoxicants and narcotics:

The insurer shall not be liable for any loss sustained or contracted in consequence of the insured's being intoxicated or under the influence of any narcotic unless administered on the advice of a physician.

(3) **Inapplicable or inconsistent provisions.** If any provision of this section is, in whole or in part, inapplicable to or inconsistent with the coverage provided by a particular form of policy, the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

(4) **Order of certain policy provisions.** The provisions which are the subject of subsections (1) and (2) of this section, or any corresponding provisions which are used in lieu thereof in accordance with such subsections, shall be printed in the consecutive order of the provisions in such subsections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be, in whole or in part, unintelligible, uncertain, ambiguous, abstruse or likely to mislead a person to whom the policy is offered, delivered or issued.

(5) **Third-party ownership.** The word "insured," as used in Sections 83-9-1 through 83-9-21, Mississippi Code of 1972, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured, or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

(6) **Requirements of other jurisdictions.**

(a) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of Sections 83-9-1 through 83-9-21, Mississippi Code of 1972, and which is prescribed or required by the law of the state under which the insurer is organized.

(b) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

(7) **Filing procedure.** The commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to the cited sections as are necessary, proper or advisable to the administration of said sections. This provision shall not abridge any other authority granted the commissioner by law.

(8) **Administrative penalties.**

(a) If the commissioner finds that an insurer, during any calendar year, has paid at least eighty-five percent (85%), but less than ninety-five percent (95%), of all clean claims received from all providers during that year in accordance with the provisions of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount not to exceed Ten Thousand Dollars ($10,000.00). If the commissioner finds that an insurer, during any calendar year, has paid at least fifty percent (50%), but less than eighty-five percent (85%), of all clean claims received from all providers during that year in accordance with the provisions of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount of not less than Ten Thousand Dollars ($10,000.00) nor more than One Hundred Thousand Dollars ($100,000.00). If the commissioner finds that an insurer, during any calendar year, has paid less than fifty percent (50%) of all clean claims received from all providers during that year in accordance with the provisions of subsection (1)(h) of this section, the commissioner may levy an aggregate penalty in an amount not less than One Hundred Thousand Dollars ($100,000.00) nor more than Two Hundred Thousand Dollars ($200,000.00). In determining the amount of any fine, the commissioner shall take into account whether the failure to achieve the standards in subsection (1)(h) of this section were due to circumstances beyond the control of the insurer. The insurer may request an administrative hearing to contest the assessment of any administrative penalty imposed by the commissioner pursuant to this subsection within thirty (30) days after receipt of the notice of assessment.

(b) Examinations to determine compliance with subsection (1)(h) of this section may be conducted by the commissioner or any of his examiners. The commissioner may contract with qualified impartial outside sources to assist in examinations to determine compliance. The expenses of any such examinations shall be paid by the insurer examined.

(c) Nothing in the provisions of subsection (1)(h) of this section shall require an insurer to pay claims that are not covered under the terms of a contract or policy of accident and sickness insurance.

(d) An insurer and a provider may enter into an express written agreement containing timely claim payment provisions which differ from, but are at least as stringent as, the provisions set forth under subsection (1)(h) of this section, and in such case, the provisions of the written agreement shall govern the timely payment of claims by the insurer to the provider. If the express written agreement is silent as to any interest penalty where claims are not paid in accordance with the agreement, the interest penalty provision of subsection (1)(h)3 of this section shall apply.

(e) The commissioner may adopt rules and regulations necessary to ensure compliance with this subsection.

HISTORY: Codes, 1942, § 5687-03; Laws, 1956, ch. 330, § 3; Laws, 1989, ch. 466, § 1; Laws, 1991, ch. 474, § 2; Laws, 2002, ch. 575, § 1; Laws, 2013, ch. 302, § 2; brought forward without change, Laws, 2014, ch. 404, § 2, eff from and after July 1, 2014; Laws, 2019, ch. 383, § 1, eff from and after July 1, 2019; Laws, 2020, ch. 420, § 1, eff from and after July 1, 2020.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected errors in this section. Corrected reference terminology in (1), (1)(b)1 and (1)(h) 4. The Joint Committee ratified the corrections at its August 16, 2012, meeting.

Cross References — Coverage of alcoholism care and treatment, see §§ 83-9-27 et seq.

Provisions for coverage of newly born children, see § 83-9-33.

Standards for policy provisions for Medicare supplement insurance policies, see § 83-9-103.

Insured's right to reimbursement for services of a licensed psychologist notwithstanding any contrary provision in a policy, plan, or contract, see § 83-41-211.

Insured's right to reimbursement for services of chiropractor and freedom of choice as to practitioner and location of services, see § 83-41-215.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Time limit on certain defenses.
3. Illegal occupation.
4. Statute of limitation.

1. In general.

Once someone who possesses uninsured motorist coverage knows, or reasonably should know, that the damages claimed to have been suffered exceed the limits of insurance available to the alleged tortfeasor, the cause of action against the uninsured motorist carrier has accrued, and it is at this point in time that a potential plaintiff has a legally enforceable claim against the uninsured motorist carrier. Jackson v. State Farm Mut. Auto. Ins. Co., 852 So. 2d 641, 2003 Miss. App. LEXIS 70 (Miss. Ct. App. 2003), rev'd, 880 So. 2d 336, 2004 Miss. LEXIS 1053 (Miss. 2004).

Insurer that issued health insurance policy to insured approximately 6 years before insured lost his hearing as complication of meningitis was not required to cover surgery to restore insured's hearing because his meningitis first manifested itself almost 30 years prior to issuance of insurance policy, well beyond incontestability provision period. Neville v. American Republic Ins. Co., 912 F.2d 813, 1990 U.S. App. LEXIS 16779 (5th Cir. Miss. 1990).

A health insurance policy exclusion for "congenital conditions" did not apply where the insured's congenital heart condition in no way manifested itself to her prior to the effective date of coverage. State v. Carper, 545 So. 2d 1, 1989 Miss. LEXIS 293 (Miss. 1989).

Major medical insurance or accident and health insurance is exempt from Mississippi Insurance Guaranty Association insolvency coverage. Mississippi Ins. Guaranty Asso. v. Vaughn, 529 So. 2d 540, 1988 Miss. LEXIS 224 (Miss. 1988).

Whether insurer acts within rights under exclusionary provisions of health insurance policy in denying claim or acts in bad faith in denying claim is factual question to be presented to jury. Blue Cross & Blue Shield, Inc. v. Campbell, 466 So. 2d 833, 1984 Miss. LEXIS 2072 (Miss. 1984).

In an action against a life insurer seeking recovery of double indemnity benefits that was filed more than four years subsequent to accrual of the claim, the trial court erred in concluding that the suit was barred by the three year statute of limitations governing accident and health insurance; although the policy, which was issued in connection with decedent's employment, was delivered to the insured rather than a master policy to the employer with a certificate to the employee, this fact did not remove the policy from the group insurance class or convert it to an individual plan; as a group policy, it was specifically exempted from the three-year statute of limitations and was controlled instead by the six-year statute of limitations. Williams v. Life Ins. Co., 367 So. 2d 922, 1979 Miss. LEXIS 2219 (Miss. 1979).

To be effective, a requirement that an accident insurance policy must be delivered during the life and good health of the insured if it is to obligate the insurer, must, under ¶ (1) of subd (A) [now (1)(a)] of this section, [Code 1942, § 5687-03] be contained in the policy itself or attached to the policy as a part of the contract of insurance. Prudence Mut. Casualty Co. v. Switzer, 253 Miss. 143, 175 So. 2d 476, 1965 Miss. LEXIS 976 (Miss. 1965).

This section [Code 1942, § 5687-03] does not authorize the cancellation of a policy before the due date of a premium which the insurer has agreed by the terms of the policy to waive. Benefit Trust Life Ins. Co. v. Lee, 248 Miss. 715, 160 So. 2d 909, 1964 Miss. LEXIS 297 (Miss. 1964).

2. Time limit on certain defenses.

Where the insured fell, was injured, and became totally disabled more than 2 years after the effective date of an accident and health policy, the fact that it was represented incorrectly in the application for the policy that insured had never been treated for or told that he had rheumatism, arthritis, lumbago, sciatica, sacroiliac disorder, or lame back did not constitute a defense to insurer's performance of the contract, in view of the provisions of subsection (A)(2)(b) [now (1)(b)2] of this section [Code 1942, § 5687-03]. Prudence Life Ins. Co. v. Smith, 197 So. 2d 799, 1967 Miss. LEXIS 1538 (Miss. 1967).

The time of commencement of a disease and the time of commencement of disability resulting from the disease are not necessarily the same. Jefferson Standard Life Ins. Co. v. O'Bryan, 192 So. 2d 263, 1966 Miss. LEXIS 1238 (Miss. 1966).

Under the provisions of ¶ (2) of subd (A) [now (1)(b)] of this section [Code 1942, § 5687-03] an insured who contracted multiple sclerosis at least a year prior to the date of issuance of a health and accident policy, but did not become disabled as a consequence until more than two years after the date of issuance, was entitled to recover, for at the time the disability occurred the policy was incontestable. Jefferson Standard Life Ins. Co. v. O'Bryan, 192 So. 2d 263, 1966 Miss. LEXIS 1238 (Miss. 1966).

3. Illegal occupation.

In an action on a major medical policy which precluded recovery for care furnished the insured injured while participating in an assault or a felony, an instruction that if the jury should find that the insured, who was hospitalized after being shot while attempting to make a citizen's arrest for a traffic offense, arrested or pursued another for the purpose of arresting without a warrant for an indictable offense or a breach of the peace threatened or attempted in his presence, it would be the jury's duty to return a verdict for the insured, was erroneous where it appeared from the evidence that the insured thought of making a citizen's arrest only after he had failed to find the sheriff and after any traffic offense had long been completed by the victim. Protective Life Ins. Co. v. Spears, 231 So. 2d 510, 1970 Miss. LEXIS 1599 (Miss. 1970).

4. Statute of limitation.

Miss. Code. Ann. § 83-9-5 requires insurers to include certain provisions in their contracts; it does not create a separate right outside the agreements made by the parties. Thus the required language in insurance contracts allows a suit to be brought at any period within three years of the time that proof of loss is required. Hood v. Cent. United Life Ins. Co., 664 F. Supp. 2d 672, 2009 U.S. Dist. LEXIS 92120 (N.D. Miss. 2009).

Grant of summary judgment against the insureds was proper where their claim against the insurer after the driver insured was injured in an accident was proper under Miss. Code Ann. 83-9-5(k) because the insureds were aware of the shortfall in coverage under the tortfeasor's own policy more than three years before they joined the insurer in the litigation. Jackson v. State Farm Mut. Auto. Ins. Co., 880 So. 2d 336, 2004 Miss. LEXIS 1053 (Miss. 2004).

OPINIONS OF THE ATTORNEY GENERAL

The provisions of Title 83, including Sections 83-9-5 and 83-9-32, which are placed squarely within the jurisdiction of the Department of Insurance, are not applicable to the State and School Employees Health Insurance Plan, which is clearly under the administration of the State and School Employees Health Insurance Management Board under the umbrella of the Department of Finance and Administration. Martinson, Dec. 6, 2002, A.G. Op. #02-0668.

The State and School Employees Health Insurance Plan is not governed by ERISA. Martinson, Dec. 6, 2002, A.G. Op. #02-0668.

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of provisions, in insurance policies allowing disability or accident benefits, which require insured to submit to physical examination. 5 A.L.R.3d 929.

Construction of incontestable clause applicable to disability insurance. 13 A.L.R.3d 1383.

Suicide clause of life or accident insurance as affected by incontestable clause. 37 A.L.R.3d 337.

Death or injury from taking illegal drugs or narcotics as accidental or result of accidental means within insurance coverage. 41 A.L.R.3d 654.

Liability under life or accident policy not containing a "violation of the law" clause, for death or injury resulting from violation of law by insured. 43 A.L.R.3d 1120.

Life or accident insurance: Sufficiency of showing that death from drowning was due to accident or accidental means. 43 A.L.R.3d 1168.

What constitutes a "hospital" within coverage or exclusionary clauses of hospitalization policy. 46 A.L.R.3d 1244.

Liability insurance: timeliness of notice of accident by additional insured. 47 A.L.R.3d 199.

What is "conveyance," "passenger conveyance" or "public conveyance" within coverage of accident policy. 60 A.L.R.3d 858.

Who is "fare-paying passenger" within coverage provision of life or accident insurance policy. 60 A.L.R.3d 1273.

What conditions constitute "disease" within terms of life, accident, disability, or hospitalization insurance policy. 61 A.L.R.3d 822.

What constitutes "one accident" or "one sickness" or related conditions or recurrences within provisions of health, accident, and disability insurance. 61 A.L.R.3d 884.

Elimination of particular coverage, or termination, of health, hospitalization, or medical care insurance policy as affecting insurer's liability for insured's continuing hospitalization or medical expenses relating to previously covered illness. 66 A.L.R.3d 1205.

Construction and application of provision in health or hospitalization policy excluding or postponing coverage of illness for which medical care or treatment was received within stated time preceding or following issuance of policy. 95 A.L.R.3d 1290.

Accident insurance: death or disability incident to partaking of food or drink as within provision as to external, violent, and accidental means. 29 A.L.R.4th 1230.

Modern status of rules requiring liability insurer to show prejudice to escape liability because of insured's failure or delay in giving notice of accident or claim, or in forwarding suit papers. 32 A.L.R.4th 141.

Accident insurance: what is "loss" of body member. 51 A.L.R.4th 156.

What constitutes single accident or occurrence within liability policy limiting insurer's liability to a specified amount per accident or occurrence. 64 A.L.R.4th 668.

Theft and vandalism insurance: coinsured's misconduct as barring innocent coinsured's right to recover on policy. 64 A.L.R.4th 714.

Insurer's duty, and effect of its failure, to provide insured or payee with copy of policy or other adequate documentation of its terms. 78 A.L.R.4th 9.

Coverage under medical and health insurance plans for services performed by dentist, oral surgeons, and orthodontists. 43 A.L.R.5th 657.

Excessiveness or adequacy of damages awarded for injuries to nerves or nervous system. 51 A.L.R.5th 467.

Excessiveness or adequacy of damages awarded for injuries causing mental or psychological damages. 52 A.L.R.5th 1.

Construction of incontestable clause applicable to disability insurance. 67 A.L.R.5th 513.

Am. Jur.

43 Am. Jur. 2d, Insurance § 68.

14A Am. Jur. Pl & Pr Forms, Rev, Insurance, Form 213.1.

Practice References.

Business Law Monographs, Volume IN2 —Casualty and Liability Insurance (Matthew Bender).

§ 83-9-6. Freedom of consumer choice for pharmacy under certain health insurance.

(1) This section shall apply to all health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of Mississippi. This section shall also apply to insurance companies and health maintenance organizations that provide or administer coverages and benefits for prescription drugs. This section shall not apply to any entity that has its own facility, employs or contracts with physicians, pharmacists, nurses and other health care personnel, and that dispenses prescription drugs from its own pharmacy to its employees and dependents enrolled in its health benefit plan; but this section shall apply to an entity otherwise excluded that contracts with an outside pharmacy or group of pharmacies to provide prescription drugs and services.

(2) As used in this section:

(a) "Copayment" means a type of cost sharing whereby insured or covered persons pay a specified predetermined amount per unit of service with their insurer paying the remainder of the charge. The copayment is incurred at the time the service is used. The copayment may be a fixed or variable amount.

(b) "Contract provider" means a pharmacy granted the right to provide prescription drugs and pharmacy services according to the terms of the insurer.

(c) "Health benefit plan" means any entity or program that provides reimbursement for pharmaceutical services.

(d) "Insurer" means any entity that provides or offers a health benefit plan.

(e) "Pharmacist" means a pharmacist licensed by the Mississippi State Board of Pharmacy.

(f) "Pharmacy" means a place licensed by the Mississippi State Board of Pharmacy.

(3) A health insurance plan, policy, employee benefit plan or health maintenance organization may not:

(a) Prohibit or limit any person who is a participant or beneficiary of the policy or plan from selecting a pharmacy or pharmacist of his choice who has agreed to participate in the plan according to the terms offered by the insurer;

(b) Deny a pharmacy or pharmacist the right to participate as a contract provider under the policy or plan if the pharmacy or pharmacist agrees to provide pharmacy services, including but not limited to prescription drugs, that meet the terms and requirements set forth by the insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer;

(c) Impose upon a beneficiary of pharmacy services under a health benefit plan any copayment, fee or condition that is not equally imposed upon all beneficiaries in the same benefit category, class or copayment level under the health benefit plan when receiving services from a contract provider;

(d) Impose a monetary advantage or penalty under a health benefit plan that would affect a beneficiary's choice among those pharmacies or pharmacists who have agreed to participate in the plan according to the terms offered by the insurer. Monetary advantage or penalty includes higher copayment, a reduction in reimbursement for services, or promotion of one participating pharmacy over another by these methods;

(e) Reduce allowable reimbursement for pharmacy services to a beneficiary under a health benefit plan because the beneficiary selects a pharmacy of his or her choice, so long as that pharmacy has enrolled with the health benefit plan under the terms offered to all pharmacies in the plan coverage area;

(f) Require a beneficiary, as a condition of payment or reimbursement, to purchase pharmacy services, including prescription drugs, exclusively through a mail-order pharmacy; or

(g) Impose upon a beneficiary any copayment, amount of reimbursement, number of days of a drug supply for which reimbursement will be allowed, or any other payment or condition relating to purchasing pharmacy services from any pharmacy, including prescription drugs, that is more costly or more restrictive than that which would be imposed upon the beneficiary if such services were purchased from a mail-order pharmacy or any other pharmacy that is willing to provide the same services or products for the same cost and copayment as any mail order service.

(4) A pharmacy, by or through a pharmacist acting on its behalf as its employee, agent or owner, may not waive, discount, rebate or distort a copayment of any insurer, policy or plan or a beneficiary's coinsurance portion of a prescription drug coverage or reimbursement and if a pharmacy, by or through a pharmacist's acting on its behalf as its employee, agent or owner, provides a pharmacy service to an enrollee of a health benefit plan that meets the terms and requirements of the insurer under a health benefit plan, the pharmacy shall provide its pharmacy services to all enrollees of that health benefit plan on the same terms and requirements of the insurer. A violation of this subsection shall be a violation of the Pharmacy Practice Act subjecting the pharmacist as a licensee to disciplinary authority of the State Board of Pharmacy.

(5) If a health benefit plan providing reimbursement to Mississippi residents for prescription drugs restricts pharmacy participation, the entity providing the health benefit plan shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit plan, and offer to the pharmacies the opportunity to participate in the health benefit plan at least sixty (60) days before the effective date of the plan or before July 1, 1995, whichever comes first. All pharmacies in the geographical coverage area of the plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. The entity providing the health benefit plan shall, through reasonable means, on a timely basis

and on regular intervals, inform the beneficiaries of the plan of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to their customers through a means acceptable to the pharmacy and the entity providing the health benefit plans. The pharmacy notification provisions of this section shall not apply when an individual or group is enrolled, but when the plan enters a particular county of the state.

(6) A violation of this section creates a civil cause of action for injunctive relief in favor of any person or pharmacy aggrieved by the violation.

(7) The Commissioner of Insurance shall not approve any health benefit plan providing pharmaceutical services which does not conform to this section.

(8) Any provision in a health benefit plan which is executed, delivered or renewed, or otherwise contracted for in this state that is contrary to this section shall, to the extent of the conflict, be void.

(9) It is a violation of this section for any insurer or any person to provide any health benefit plan providing for pharmaceutical services to residents of this state that does not conform to this section.

HISTORY: Laws, 1994, ch. 475, § 1; Laws, 1997, ch. 321, § 1, eff from and after July 1, 1997.

Cross References — Freedom of choice of pharmacy providers for patients in long-term care facilities, see § 43-11-1.

Mississippi Pharmacy Practice Act, see §§ 73-21-71 through 73-21-129.

JUDICIAL DECISIONS

1. Applicablity.

Miss. Code Ann. § 83-9-6 applies to the Mississippi State and School Employees' Life and Health Plan because it applies to "all health benefit plans providing pharmaceutical services benefits, including prescription drugs, to any resident of Mississippi" and is not ambiguous. Miss. State & Sch. Emples. Life & Health Plan v. KCC, Inc., 108 So. 3d 932, 2013 Miss. LEXIS 69 (Miss. 2013).

§ 83-9-6.1. Pharmacy cash discount cards; cannot be issued unless issuer pays portion of discount given by pharmacy.

(1) As used in this section:

(a) "Cash discount card" means a card, other than the program identification card of a member or participant of a prescription drug program, that allows the holder to obtain a discount on a prescription drug when paying for the prescription at the point-of-sale.

(b) "Prescription drug program" means a program or plan that provides coverages and benefits for prescription drugs for members or participants in the program, whether the program is a separate program or part of a health benefit plan.

(2) Any entity that administers a prescription drug program through a

network of participating pharmacies for the benefit of any resident of the State of Mississippi shall not issue or distribute any cash discount card that the participating pharmacies must accept or honor as a condition or requirement of participation in the prescription drug program, or that the participating pharmacies must accept or honor if they accept or honor program identification cards held by members or participants of any prescription drug program administered by the entity, unless the entity pays a portion of the cost of the discount given by the pharmacy for prescriptions purchased with the use of the cash discount card.

(3) Any person or entity that is not subject to subsection (2) of this section shall not issue or distribute any cash discount card to any resident of the State of Mississippi unless the person or entity pays a portion of the cost of the discount given by the pharmacy for prescriptions purchased with the use of the cash discount card.

(4) Any provision in any prescription drug program or health benefit plan that is executed, delivered, renewed or otherwise contracted for in this state that is not in compliance with this section shall be void to the extent of the noncompliance.

(5) The provisions of this section shall not apply to the issuers of Medicare Supplement Insurance policies.

(6) The Office of Attorney General, Consumer Protection Division, shall enforce the provisions of this section.

HISTORY: Laws, 1999, ch. 545, § 1, eff from and after July 1, 1999.

§ 83-9-6.2. Uniform prescription identification.

(1) Every health benefit plan that provides coverage for prescription drugs or devices, or that administers such a plan, including, but not limited to, health maintenance organizations and third-party administrators for self-insured plans, shall issue to each insured a card or other technology containing standardized pharmacy benefit identification information. The card shall contain at a minimum the following information:

(a) The card issuer's name or logo on the front of the card;

(b) The cardholder's name and identification number, which shall be displayed on the front side of the card;

(c) The American National Standards Institute Issuer Identification Number assigned to the administrator or pharmacy benefit manager of the plan, when required for proper claims adjudication;

(d) The processor's control number, when required for proper claims adjudication;

(e) The insured's group number, when required for proper claims adjudication;

(f) The name and address of the benefits administrator or other entity responsible for prescription claims submission, adjudication or pharmacy provider correspondence for prescription benefits; and

(g) A help desk telephone number that pharmacy providers may call for pharmacy benefit claims assistance.

(2) This section does not require a health benefit plan to issue an identification card separate from any identification card issued to an enrollee to evidence coverage under the health benefit plan if the identification card contains the elements required by subsection (1) of this section.

(3) In order to ensure that insurance identification cards issued under this section contain accurate and updated information, each health benefit plan shall provide each subscriber with a new insurance identification card within a reasonable time after any information required for proper claims adjudication is changed.

(4) As used in this section, "health benefit plan" means any hospital or medical policy or certificate, hospital or medical service contract or health maintenance organization, a plan provided by a fully insured multiple employer welfare arrangement or any other entity providing a plan of health insurance subject to the jurisdiction of the Commissioner of Insurance and to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by the Health Insurance Portability and Accountability Act of 1996. A health benefit plan does not include the following:

(a) Accident;
(b) Credit;
(c) Disability income;
(d) Long-term or nursing home care;
(e) Specified disease;
(f) Dental or vision;
(g) Coverage issued as a supplement to liability insurance;
(h) Medical payments under automobile or homeowners;
(i) Insurance under which benefits are payable with or without regard to fault and that is required statutorily to be contained in any liability or equivalent self-insurance; and
(j) Hospital income or indemnity.

(5) The Commissioner of Insurance may issue any rules or regulations necessary to implement the provisions of this section, and he may use the standards produced by the National Council for Prescription Drugs Programs as a guide in developing such rules and regulations.

(6) This section applies to plans that are delivered, issued for delivery or renewed on or after January 1, 2003. For purposes of this section, renewal of a health benefit policy, contract or plan is presumed to occur on the anniversary date.

HISTORY: Laws, 2002, ch. 589, § 1, eff from and after Jan. 1, 2003.

Federal Aspects — Employee Retirement Income Security Act of 1974, see 29 USCS Section 1001 et seq. The Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, is codified in various sections of 29 USCS (see 29 USCS §§ 1181 et seq.) and 42 USCS (see §§ 1320d et seq.).

§ 83-9-6.3. Standardized prior authorization form for obtaining prior authorization for prescription drug benefits.

(1) As used in this section:

(a) "Health benefit plan" means services consisting of medical care, provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization, or health maintenance organization contract offered by a health insurance issuer. The term "health benefit plan" includes the Medicaid fee-for-service program and any managed care program, coordinated care program, coordinated care organization program or health maintenance organization program implemented by the Division of Medicaid.

(b) "Health insurance issuer" means any entity that offers health insurance coverage through a health benefit plan, policy, or certificate of insurance subject to state law that regulates the business of insurance. "Health insurance issuer" also includes a health maintenance organization, as defined and regulated under Section 83-41-301 et seq., and includes the Division of Medicaid for the services provided by fee-for-service and through any managed care program, coordinated care program, coordinated care organization program or health maintenance organization program implemented by the division.

(c) "Prior authorization" means a utilization management criterion used to seek permission or waiver of a drug to be covered under a health benefit plan that provides prescription drug benefits.

(d) "Prior authorization form" means a standardized, uniform application developed by a health insurance issuer for the purpose of obtaining prior authorization.

(2) Notwithstanding any other provision of law to the contrary, in order to establish uniformity in the submission of prior authorization forms, on or after January 1, 2014, a health insurance issuer shall use only a single, standardized prior authorization form for obtaining any prior authorization for prescription drug benefits. The form shall not exceed two (2) pages in length, excluding any instructions or guiding documentation. The form shall also be made available electronically, and the prescribing provider may submit the completed form electronically to the health benefit plan. Additionally, the health insurance issuer shall submit its prior authorization forms to the Mississippi Department of Insurance to be kept on file on or after January 1, 2014. A copy of any subsequent replacements or modifications of a health insurance issuer's prior authorization form shall be filed with the Mississippi Department of Insurance within fifteen (15) days prior to use or implementation of such replacements or modifications.

(3) A health insurance issuer shall respond within two (2) business days upon receipt of a completed prior authorization request from a prescribing

provider that was submitted using the standardized prior authorization form required by subsection (2) of this section.

HISTORY: Laws, 2013, ch. 508, § 1, eff from and after July 1, 2013.

§ 83-9-6.4. Individual and group health insurance policies to permit partial supply of prescription medication for purpose of synchronizing patient's medication under certain circumstances.

(1) An individual or group health insurance policy providing prescription drug coverage in the state shall permit and apply a prorated daily cost-sharing rate to prescriptions that are dispensed by a network pharmacy for a partial supply if the prescriber or pharmacist determines the fill or refill to be in the best interest of the patient and the patient requests or agrees to a partial supply for the purpose of synchronizing the patient's medications.

(2) No individual or group health insurance policy providing prescription drug coverage shall deny coverage for the dispensing of a medication that is dispensed by a network pharmacy on the basis that the dispensing is for a partial supply if the prescriber or pharmacist determines the fill or refill to be in the best interest of the patient and the patient requests or agrees to a partial supply for the purpose of synchronizing the patient's medications.

(3) No individual or group health insurance policy providing prescription drug coverage shall use payment structures incorporating prorated dispensing fees. Dispensing fees for partially filled or refilled prescriptions shall be paid in full for each prescription dispensed, regardless of any prorated daily cost-sharing rate for the beneficiary or fee paid for alignment services.

(4) The provisions of this section shall be fully applicable to any managed health care delivery entities including the State and School Employees Health Insurance Plan and the Mississippi Medicaid Program.

HISTORY: Laws, 2018, ch. 308, § 1, eff from and after January 1, 2019.

§ 83-9-7. Benefits to patients in tax-supported institutions.

No policy of sickness and accident insurance delivered or issued for deliverance after August 6, 1968, to any person in this state, including both individual policies and group policies, which provide coverage for tuberculosis or mental illness or any other illness, shall exclude hospitalization benefits for such patients hospitalized in tax-supported institutions of the State of Mississippi or any county or municipality thereof, whether such institution be deemed charitable or otherwise. However, only that portion or percent of the benefits shall be payable that have been assigned to said eleemosynary institution as payment in whole or in part for services rendered by such institution.

HISTORY: Codes, 1942, § 5687-03.5; Laws, 1968, ch. 476, § 1, eff from and after passage (approved August 6, 1968).

§ 83-9-8. Coverage of drugs not approved by Federal Food and Drug Administration; drugs used in treatment of cancer.

(1) No insurance policy which provides coverage for drugs shall exclude coverage of any such drug used for the treatment of cancer on the grounds that the drug has not been approved by the Federal Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, provided that such drug is recognized for treatment of that specific type of cancer in one of the standard reference compendia or in the medical literature.

(2) This section may not be construed to:

(a) Alter existing law with regard to provisions limiting the coverage of drugs that have not been approved by the Federal Food and Drug Administration;

(b) Require coverage for any drug when the Federal Food and Drug Administration has determined its use to be contraindicated;

(c) Require coverage for experimental drugs not otherwise approved for any indication by the Federal Food and Drug Administration;

(d) Create, impair, alter, limit, modify, enlarge, abrogate or prohibit reimbursement for drugs used in the treatment of any other disease or condition.

(3) For purposes of this section:

(a) "Insurance policy" means an individual, group or blanket policy written by a medical expense indemnity corporation, a hospital service corporation, a health care service plan contract, or a private insurance plan issued, amended, delivered or renewed in this state or which provides insurance for residents of this state. This term shall include all health insurance plans for the state and its political subdivisions.

(b) "Standard reference compendia" means:

(i) The United States Pharmacopoeia Drug Information;

(ii) The American Hospital Formulary Service Drug Information.

(c) "Medical literature" means two (2) articles from major peer-reviewed professional medical journals that have recognized, based on scientific or medical criteria, the drug's safety and effectiveness for treatment of the indication for which it has been prescribed unless two (2) articles from major peer-reviewed professional medical journals have concluded, based on scientific or medical criteria, that the drug is unsafe or ineffective or that the drug safety and effectiveness cannot be determined for the treatment of the indication for which it has been prescribed. Peer-reviewed medical literature shall not include publications or supplements that are sponsored to a significant extent by a pharmaceutical manufacturing company or health carrier.

HISTORY: Laws, 1997, ch. 445, § 1, eff from and after July 1, 1997.

§ 83-9-9. Conforming to statute.

(1) **Other policy provisions.** No policy provision which is not subject to Section 83-9-5 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to Sections 83-9-1 through 83-9-21.

(2) **Policy conflicting with this statute.** A policy delivered or issued for delivery to any person in this state in violation of Sections 83-9-1 through 83-9-21 shall be held valid but shall be construed as provided in said sections. When any provision in a policy subject to the cited sections is in conflict with any provision of said sections, the rights, duties, and obligations of the insurer, the insured, and the beneficiary shall be governed by the provisions of such sections.

HISTORY: Codes, 1942, § 5687-04; Laws, 1956, ch. 330, § 4, eff July 1, 1956.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

§ 83-9-11. Application.

(1) The insured shall not be bound by any statement made in an application for a policy unless a copy of such application is attached to or endorsed on the policy when issued as a part thereof. If any such policy delivered or issued for delivery to any person in this state shall be reinstated or renewed, and the insured or the beneficiary or assignee of such policy shall make written request to the insurer for a copy of the application, if any, for such reinstatement or renewal, the insurer shall, within fifteen (15) days after the receipt of such request at its home office or any branch office of the insurer, deliver or mail to the person making such request a copy of such application. If such copy shall not be so delivered or mailed, the insurer shall be precluded from introducing such application as evidence in any action or proceeding based upon or involving such policy or its reinstatement or renewal.

(2) No alteration of any written application for any such policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

(3) The falsity of any statement in the application for any policy covered by Sections 83-9-1 through 83-9-21 may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

HISTORY: Codes, 1942, § 5687-05; Laws, 1956, ch. 330, § 5, eff July 1, 1956.

JUDICIAL DECISIONS

1. In general.

Summary judgment was improperly granted to the insurer where the decedent's promise not to travel out of Mississippi in her rental car was akin to a false statement regarding health. Hancock v. Mid Am. Ins. Servs., 836 So. 2d 762, 2003 Miss. LEXIS 49 (Miss. 2003).

False statements made by decedent in his application for life insurance (denying his recent hospitalization for chemical dependency, cocaine use, and consultation with physician) constituted "material" misrepresentations, justifying insurer's post claim rescission of policy under § 83-9-11(3). Wesley v. Union Nat'l Life, 919 F. Supp. 232, 1995 U.S. Dist. LEXIS 20651 (S.D. Miss. 1995).

Insurer did not engage in post claim underwriting when it rescinded life insurance policy under § 83-9-11(3) on learning that insured had made material misrepresentations in his policy application concerning his recent hospitalization, his cocaine use, and consultation with physician; rather, it was insured who bypassed insurer's underwriting process. Wesley v. Union Nat'l Life, 919 F. Supp. 232, 1995 U.S. Dist. LEXIS 20651 (S.D. Miss. 1995).

Right of insurer to void or rescind policy occurs only when answers given in application are both false and material to acceptance of risk or hazard to be assumed; if misstatement is material, it can make no difference whether or not it was made in good faith. Massachusetts Mut. Life Ins. Co. v. Nicholson, 775 F. Supp. 954, 1991 U.S. Dist. LEXIS 14406 (N.D. Miss. 1991).

Insured's response on insurance application indicating that she and her husband had never been denied issuance or renewal of auto insurance coverage, when in fact renewal had been denied on a previous occasion, raised question of fact as to whether statement on policy was material misrepresentation which would permit insurer to rescind policy based on discrepancy in statements as to reason for previous nonrenewal of policy. Chapman v. Safeco Ins. Co., 722 F. Supp. 285, 1989 U.S. Dist. LEXIS 10768 (N.D. Miss. 1989).

Insured is not bound by misrepresentations, if any, in telephone interview with representative of insurance company, where insured testified that she was not asked question concerning treatment within 10 years during telephone interview, and examination of form shows that "answer" recorded thereon contradicts answers to earlier questions. Guy v. Commonwealth Life Ins. Co., 698 F. Supp. 1305 (N.D. Miss. 1988), aff'd in part, rev'd on other grounds, 894 F.2d 1407 (5th Cir. 1990), reh'g denied (5th Cir. 1990).

Even if failure to reveal doctors who had treated wife insured other than listed doctor, and failure of husband insured to list family physician, was misrepresentation, information was not material to risk being assumed, and therefore insurance company was not entitled to rescind policy. Mattox v. Western Fidelity Ins. Co., 694 F. Supp. 210, 1988 U.S. Dist. LEXIS 10254 (N.D. Miss. 1988).

To entitle insurer to rescind policy, alleged misrepresentations made must affect either acceptance of risk or hazard assumed by company; where insurance company's chief underwriter stated that lack of any family physician information on husband did not affect acceptance of major medical policy application for husband and wife, company could not complain after submission of claim that applicants' failure to disclose names of more then one physician for wife was material misrepresentation entitling company to rescind policy; if applicant divulges information, but agent who fills out form does not record information accurately, there has been no misrepresentation, and fact that applicant signed application and initialed each entry which company claims were misrepresentations is of no affect because signing of completed application by insured does not undo fact that insured has communicated information to agent; by issuing policy and accepting premiums with full knowledge that applicant was being treated for high blood pressure and that this information did not appear on application, insurance company waived right to rescind policy for that "misrepresentation"; uninsurability alone is not grounds for rescission of policy, and although company has right to rely on information supplied in application in determining whether or not to accept risk, company has no right to rescind policy because there was information, not asked for on application and not volunteered by applicant, knowledge of which would have caused company to refuse to insure. Mattox v. Western Fidelity Ins. Co., 694 F. Supp. 210, 1988 U.S. Dist. LEXIS 10254 (N.D. Miss. 1988).

Because insurer is not required to show intent to deceive in order to void policy based on misrepresentations in application, insured's good faith is irrelevant. Pedersen v. Chrysler Life Ins. Co., 677 F. Supp. 472, 1988 U.S. Dist. LEXIS 209 (N.D. Miss. 1988).

Insurer proved existence of misrepresentation by clear and convincing evidence where insured stated on application that he had not seen physician for treatment of heart trouble in 6 month period preceding effective date of policy, but insured's wife did not contest fact that her husband was being treated for heart trouble in that period. Pedersen v. Chrysler Life Ins. Co., 677 F. Supp. 472, 1988 U.S. Dist. LEXIS 209 (N.D. Miss. 1988).

Insurer met its burden with regard to element of materiality where manager of claims department stated that insurer relied on health representations made by customers when applying for insurance, insurer did not issue life insurance policy if applicant had been treated for heart failure within 6 months prior to date of application, and had insurer known of insured's medical history, it would not have issued policy. Pedersen v. Chrysler Life Ins. Co., 677 F. Supp. 472, 1988 U.S. Dist. LEXIS 209 (N.D. Miss. 1988).

The materiality of a representation on an insurance application is determined by the probable and reasonable effect which truthful answers would have had on the insurer. Sanford v. Federated Guaranty Ins. Co., 522 So. 2d 214, 1988 Miss. LEXIS 150 (Miss. 1988).

Where an insurance policy contradicted itself as to whether answers in the application were "warranties" or mere "representations," they were required to be construed as representations. Sanford v. Federated Guaranty Ins. Co., 522 So. 2d 214, 1988 Miss. LEXIS 150 (Miss. 1988).

In an insured's action to recover under a hospitalization policy, and to recover punitive damages for the insurer's failure to pay the insured's claim under the policy, a jury question was made out as to whether the insured made false statements on the policy application that would permit the insurer to cancel the policy months later, after the claim was made, pursuant to § 83-9-11(3), and as to whether the insurer had a legitimate and arguable reason to prevail in its affirmative defense that the answers given by the insured on the policy application were materially false to the extent that the policy could be arbitrarily voided ab initio under § 83-9-11(3). Reserve Life Ins. Co. v. McGee, 444 So. 2d 803, 1983 Miss. LEXIS 3059 (Miss. 1983).

The provisions of subd (C) [now (3)] of this section [Code 1942, § 5687-05], are applicable to the situation where the insured, although signing applications for policies in blank, gained knowledge of errors and insufficiencies in the applications when the policies were delivered. Reserve Life Ins. Co. v. Brunson, 252 Miss. 20, 172 So. 2d 571, 1965 Miss. LEXIS 1070 (Miss. 1965).

The question of whether the misrepresentations of an insured as to her medical history materially affected either the insurer's acceptance of the risk or the hazard it assumed is one for the jury. Reserve Life Ins. Co. v. Brunson, 252 Miss. 20, 172 So. 2d 571, 1965 Miss. LEXIS 1070 (Miss. 1965).

An insurer who relied upon the false statements of the insured as materially affecting the acceptance of the risk or the hazard assumed has the burden of going forward with the proof as to this issue. Reserve Life Ins. Co. v. Brunson, 252 Miss. 20, 172 So. 2d 571, 1965 Miss. LEXIS 1070 (Miss. 1965).

RESEARCH REFERENCES

ALR.
Insurer's duty, and effect of its failure, to provide insured or payee with copy of policy or other adequate documentation of its terms. 78 A.L.R.4th 9.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 313-319.

14A Am. Jur. Pl & Pr Forms, Rev, Insurance, Form 213.1.

3 Am. Jur. Proof of Facts 3d 367, Materiality of Applicant's Misrepresentation in Application for Life or Health Insurance.

CJS.
44 C.J.S., Insurance §§ 403, 428-431.

§ 83-9-13. Waiver; proof-of-loss form; revision of form.

(1) The acknowledgment by any insurer of the receipt of notice given under any policy covered by Sections 83-9-1 through 83-9-21, or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder, shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

(2) The Commissioner of Insurance shall prescribe the use of the National Uniform Bill-82 (UB-82) and the Health Care Financing Administration (HCFA) Form 1500 as the uniform proof of loss forms. After July 1, 1985, no insurance company writing policies of accident and sickness insurance may require proof of loss to be on any claim form but the UB-82 or HCFA Form 1500, whichever is appropriate for services rendered.

(3) The Commissioner of Insurance shall review the uniform proof of loss forms prescribed under subsection (2), seek comments and suggestions from insurers and consumer groups about proposed improvements to the forms, and determine whether any revisions should be made to either form that would simplify or otherwise improve the form. If the commissioner determines that either form should be revised, he shall make the revisions to the form and prescribe the use of the revised form by all insurance companies writing policies of accident and sickness insurance in Mississippi. After six (6) months from the date that the commissioner has prescribed the use of any revised form, no insurance company writing policies of accident and sickness insurance may require proof of loss to be on any claim form but the revised form when that is the appropriate form for services rendered.

HISTORY: Codes; , 1942, § 5687-06; Laws, 1956, ch. 330, § 6; Laws, 1971, ch. 419, § 1; Laws, 1974, ch. 397; Laws, 1985, ch. 370; Laws, 1993, ch. 336, § 1, eff from and after July 1, 1993.

JUDICIAL DECISIONS

1. In general.
The fact that an insurer under a hospital services policy had paid on a claim of cancer, prior to the effective date of a revised catastrophic illness indorsement, did not waive the rights of the insurer under a clause of the indorsement which provided that no benefits were to accrue thereunder on account of cancer in a case where the patient had had cancer before the effective date of the indorsement. Mississippi Hospital & Medical Service v. Lumpkin, 229 So. 2d 573, 1969 Miss. LEXIS 1251 (Miss. 1969).

RESEARCH REFERENCES

Am. Jur.

44 Am. Jur. 2d, Insurance §§ 1444 et seq.

14A Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 332 (answer in action by trustee that beneficiary did not sign proof of loss or submit to questioning-trustee's proof alone insufficient); Form No. 333 (answer alleging failure to give notice or make sufficient proof of loss); Form No. 334 (instructions to jury as to proof of loss); Form Nos. 341-343 (complaint or declaration-allegations as to waiver of written proof of loss-expressly made); Form No. 346 (instruction to jury as to waiver of proof of loss-acceptance of proof in different format-effect of insurer's failure to furnish blank form).

CJS.

45 C.J.S., Insurance §§ 1417 et seq.

§ 83-9-15. Age limit.

If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force, subject to any right of cancellation, until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

HISTORY: Codes, 1942, § 5687-07; Laws, 1956, ch. 330, § 7, eff July 1, 1956.

RESEARCH REFERENCES

Am. Jur.

44 Am. Jur. 2d, Insurance §§ 765, 770, 772-775.

14A Am. Jur. Pl & Pr Forms, Rev, Insurance, Form 213.1.

CJS.

44 C.J.S., Insurance §§ 381, 382.

45 C.J.S., Insurance §§ 676-682, 1092.

§ 83-9-17. Non-application to certain policies.

Nothing in Sections 83-9-1 through 83-9-21 shall apply to or affect (a) any policy of workmen's compensation insurance or any policy of liability insurance with or without supplementary coverage therein; or (b) any policy or contract of reinsurance; or (c) life insurance, endowment or annuity contracts, or contracts supplemental thereto, which contain only such provisions relating to accident and sickness insurance as (a) provide additional benefits in case of death or dismemberment or loss of sight by accident, or as (b) operate to safeguard such contracts against lapse, or to give a special surrender value or special benefit or an annuity in the event that the insured or annuitant shall become totally and permanently disabled, as defined by the contract or supplemental contract.

HISTORY: Codes, 1942, § 5687-08; Laws, 1956, ch. 330, § 8, eff July 1, 1956; Laws, 1996, ch. 320, § 1, eff from and after July 1, 1996.

Editor's Notes — Chapter 408 of Laws, 1984 (§ 71-3-1) changed the title of the Workmen's Compensation Law to "Workers' Compensation Law" and provided that the words "workmen's compensation" shall mean "workers' compensation" and "commission" shall mean "workers' compensation commission."

JUDICIAL DECISIONS

1. In general.

In an action against a life insurer seeking recovery of double indemnity benefits that was filed more than four years subsequent to accrual of the claim, the trial court erred in concluding that the suit was barred by the three year statute of limitations governing accident and health insurance; although the policy, which was issued in connection with decedent's employment, was delivered to the insured rather than a master policy to the employer with a certificate to the employee, this fact did not remove the policy from the group insurance class or convert it to an individual plan; as a group policy, it was specifically exempted from the three-year statute of limitations and was controlled instead by the six-year statute of limitations. Williams v. Life Ins. Co., 367 So. 2d 922, 1979 Miss. LEXIS 2219 (Miss. 1979).

RESEARCH REFERENCES

Law Reviews.

1979 Mississippi Supreme Court Review: Insurance. 50 Miss. L. J. 813.

§ 83-9-19. Penalty.

Any person, partnership, or corporation wilfully violating any provision of Sections 83-9-1 through 83-9-21, or order of the commissioner made in accordance with said sections, shall forfeit to the people of the state a sum not less than Fifty Dollars ($50.00) nor more than One Thousand Dollars ($1,000.00) for each such violation, which may be recovered by a civil action. The commissioner may also suspend or revoke the license of an insurer or agent for any such wilful violation.

HISTORY: Codes, 1942, § 5687-09; Laws, 1956, ch. 330, § 9, eff July 1, 1956.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 69.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance § 139.

§ 83-9-21. Judicial review.

Any order or decision of the commissioner under Sections 83-9-1 through 83-9-21 shall be subject to review by appeal (writ of certiorari) to the circuit court at the instance of any party in interest. The filing of the appeal (petition for such writ) shall operate as a stay of any such order or decision until the court directs otherwise. The court may review all the facts and, in disposing of the issue before it, may modify, affirm, or reverse the order or decision of the commissioner in whole or in part.

HISTORY: Codes, 1942, § 5687-10; Laws, 1956, ch. 330, § 10, eff July 1, 1956.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-9-22. Health coverage plans prohibited from restricting coverage for medically appropriate treatment prescribed by physician based on insured's diagnosis with terminal condition.

(1)(a) Notwithstanding any other provision of the law to the contrary, except as otherwise provided in subsection (3) of this section, no health coverage plan shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed insured, or if the insured lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an insured's diagnosis with a terminal condition. Refusing to pay for treatment rendered to an insured near the end of life that is consistent with best practices for treatment of a disease or condition, approved uses of a drug or device, or uses supported by peer reviewed medical literature, is a per se violation of this section.

(b) Violations of this section shall constitute an unfair trade practice and subject the violator to the penalties provided by law.

(c) As used in this section "terminal condition" means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which a physician diagnoses as terminal.

(d) As used in this section, a "health coverage plan" shall mean any hospital, health or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and the State Health and Life Insurance Plan.

(2)(a) Notwithstanding any other provision of the law to the contrary, no health benefit paid directly or indirectly with state funds, specifically Medicaid, shall restrict coverage for medically appropriate treatment prescribed by a physician and agreed to by a fully informed individual, or if the individual lacks legal capacity to consent by a person who has legal authority to consent on his or her behalf, based on an individual's diagnosis with a terminal condition.

(b) Refusing to pay for treatment rendered to an individual near the end of life that is consistent with best practices for treatment of a disease or condition, approved uses of a drug or device, or uses supported by peer reviewed medical literature, is a per se violation of this section.

(c) As used in this section "terminal condition" means any aggressive malignancy, chronic end-stage cardiovascular or cerebral vascular disease, or any other disease, illness or condition which a physician diagnoses as terminal.

(3) This section does not require a health coverage plan to cover and pay for the treatment of a person who is a cardholder and registered qualifying patient with medical cannabis that is lawful under the Mississippi Medical Cannabis Act and in compliance with rules and regulations adopted thereunder.

HISTORY: Laws, 2014, ch. 439, § 1, eff from and after July 1, 2014; Laws, 2022, ch. 303, § 73, eff from and after passage (approved February 2, 2022).

Amendment Notes — The 2022 amendment, effective February 2, 2022, in (1)(a), inserted the exception; and added (3).

Cross References — Mississippi Medical Cannabis Act, see §§ 41-137-1 et seq.

Mississippi Medical Cannabis Act, see § 41-137-1 et seq.

§ 83-9-23. Health and accident insurance for resident senior citizens.

(1) Any insurance company authorized to do business of health insurance in this state may join with one or more other such insurance companies to offer to any resident of this state who is sixty-five (65) years of age or older, and to the spouse of such resident, insurance against major financial loss from accident or disease. Such insurance may be offered by such companies in their own names or in the name of a voluntary unincorporated association or other organization formed by such companies solely for the purpose of this section. The forms of applications, certificates, and policies of such insurance and the applicable premium rates shall be filed with the insurance commissioner, who may require additional pertinent information.

(2) A financial summary concerning any insurance written under the authority of this section shall be furnished annually to the insurance commissioner in such form as he may prescribe. If the insurance commissioner finds that any forms for such insurance are not in the public interest or that the premium rates charged are, by reasonable assumptions, excessive in relation to the benefits provided, he may disapprove such forms or premium rates after notice of at least twenty (20) days and hearing.

(3) Any person aggrieved by the decision of the commissioner under the provisions of this section may appeal therefrom within thirty (30) days after

receipt of notice thereof to the Chancery Court of the First Judicial District of Hinds County by writ of certiorari, upon giving bond with surety or sureties and in such penalty as shall be approved by the chancery court of said county, conditioned that such appellant will pay all cost of the appeal in the event such appeal is unsuccessful. The said chancery court shall have the authority and jurisdiction to hear said appeal and render its decision in regard thereto, either in term time or vacation.

HISTORY: Codes, 1942, § 5687-21; Laws, 1962, ch. 470, §§ 1-3, eff from and after passage (approved February 13, 1962).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 67 et seq.

§ 83-9-24. Prohibition against requiring higher co-payment, coinsurance, etc., for patient-administered anti-cancer medications than is required for anti-cancer medications injected or intravenously administered by health care provider.

(1)(a) As used in this section, the following terms shall be defined as provided in this subsection:

(b) "Anti-cancer medication" means drugs and biologics that are used to kill, slow, or prevent the growth of cancerous cells.

(c) "Health plan or policy" means any hospital, health or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan and the State and School Employees Life and Health Insurance Plan.

(2) Any health plan or policy delivered, issued for delivery or renewed in this state on or after January 1, 2016, that covers anti-cancer medications that are injected or intravenously administered by a health care provider and patient-administered anti-cancer medications, including, but not limited to, those orally administered or self-injected, may not require a higher co-payment, deductible or coinsurance amount for patient-administered anti-cancer medications than it requires for injected or intravenously administered anti-cancer medications, regardless of the formulation or benefit category determination by the policy or plan.

(3) The health insurance policy or plan may not comply with subsection (2) of this section by:

(a) Increasing the co-payment, deductible or coinsurance amount required for injected or intravenously administered anti-cancer medications that are covered under the policy or plan; or

(b) Reclassifying benefits with respect to anti-cancer medications.

HISTORY: Laws, 2015, ch. 490, § 1, eff from and after July 1, 2015.

Cross References — State health plan cannot require higher co-payment, coinsurance, etc., for patient-administered anti-cancer medications than it requires for anti-cancer medications injected or intravenously adminitered by health care provider, see § 25-15-9.

§ 83-9-25. Examination and return of policy.

Every individual accident and health policy or service contract, except travel or nonrenewable accident policies, issued for delivery in the State of Mississippi on or after July 1, 1971, by an insurance company, nonprofit hospital service plan, or medical service corporation shall have printed thereon or attached thereto a notice stating, in substance, that the person to whom the policy or contract is issued shall be permitted to return the policy or contract within not less than ten (10) days of its delivery to said purchaser and to have the premium paid refunded if, after examination of the policy or contract, the purchaser is not satisfied with it for any reason. If a policyholder or purchaser, pursuant to such notice, returns the policy or service contract to the insurance company or association at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning, and the parties shall be in the same position as if no policy or service contract had been issued.

HISTORY: Codes, 1942, § 5687-31; Laws, 1971, ch. 452, § 1, eff from and after July 1, 1971.

RESEARCH REFERENCES

ALR.

Insurer's duty, and effect of its failure, to provide insured or payee with copy of policy or other adequate documentation of its terms. 78 A.L.R.4th 9.

Am. Jur.

43 Am. Jur. 2d, Insurance § 263.

CJS.

44 C.J.S., Insurance §§ 416-419.

§ 83-9-26. Screening, diagnosis and treatment of autism spectrum disorder.

(1) Except as otherwise provided herein, a health insurance policy shall provide coverage for the screening, diagnosis, and treatment of autism spectrum disorder. To the extent that the screening, diagnosis, and treatment of autism spectrum disorder are not already covered by a health insurance policy, coverage under this section will be included in health insurance policies that are delivered, executed, issued, amended, adjusted, or renewed in this state, or outside this state if insuring residents of this state, on or after January 1, 2016. No insurer can terminate coverage, or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with or has received treatment for an autism spectrum disorder.

(2) Coverage under this section must not be subject to dollar limits, deductibles, or coinsurance provisions that are less favorable to an insured than the dollar limits, deductibles, or coinsurance provisions that apply to substantially all medical and surgical benefits under the health insurance policy, except as otherwise provided in subsection (5) of this section.

(3) This section shall not be construed as limiting benefits that are otherwise available to an individual under a health insurance policy.

(4) As used in this section:

(a) "Applied behavior analysis" means the individualized design, implementation, and evaluation of instructional and environmental modifications to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(b) "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the edition that was in effect at the time of diagnosis.

(c) "Behavioral health treatment" means behavior modification and mental health counseling and treatment programs, including applied behavior analysis, that are:

(i) Necessary to develop or restore, to the maximum extent practicable, the functioning of an individual; and

(ii) Provided or supervised by a licensed behavior mental health professional, so long as the services performed are commensurate with the licensed mental health professional's competency area, training and supervised experience.

(d) "Diagnosis of autism spectrum disorder" means medically necessary assessment, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder, as performed by a licensed psychologist or licensed physician.

(e) "Licensed behavior analyst" means a professional licensed under Section 73-75-13(d) to practice applied behavior analysis in the State of Mississippi.

(f) "Health insurance policy" includes all individual and group health insurance policies providing coverage on an expense-incurred basis, individual and group service or indemnity type contracts issued by a nonprofit corporation, individual and group service contracts issued by a health maintenance organization or preferred provider organization, all self-insured group arrangements to the extent not preempted by federal law, all plans for state and political subdivisions and all managed health care delivery entities of any type or description providing coverage to any resident of this state.

(g) "Pharmacy care" means medications approved by the United States Food and Drug Administration and prescribed by a licensed physician, and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

(h) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed to practice in the State of Mississippi or as provided under the applicable health insurance policy.

(i) "Psychological care" means direct or consultative services provided by a psychologist licensed to practice in the State of Mississippi or as provided under the applicable health insurance policy.

(j) "Therapeutic care" means services provided by licensed speech-language pathologists, occupational therapists, or physical therapists as covered by the health insurance policy.

(k) "Treatment for autism spectrum disorder" means evidence-based care prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary, including, but not limited to:

(i) Behavioral health treatment;
(ii) Pharmacy care;
(iii) Psychiatric care;
(iv) Psychological care; and
(v) Therapeutic care.

(*l*) "Treatment plan" means a written, comprehensive, and individualized intervention plan that incorporates specific treatment goals, individualized with objectives, data collection and analysis plan, and goal change procedures if goals are not met.

(5) Coverage under this section for applied behavior analysis shall be limited to twenty-five (25) hours per week, and shall not be required beyond the age of eight (8) years. No more than ten (10) hours per week shall be for the services of a licensed behavior analyst; however, all services must be provided under the supervision or direction of a licensed behavior analyst or licensed psychologist. Coverage for applied behavior analysis pursuant to an ongoing treatment plan may be extended beyond the limits provided in this subsection if medical necessity for the extension is determined to exist, or in the event of disagreement, the appeal rights under the applicable health insurance policy shall govern.

(6) Except for inpatient services, if an insured is receiving treatment for an autism spectrum disorder, an insurer shall have the right to review the treatment plan every six (6) months, unless the insurer and the insured's treating physician or psychologist agree that a more frequent review is necessary. The cost of obtaining any review of the treatment plan shall be borne by the insurer.

(7) This section shall not be construed to require an insurer to provide coverage for any services to an individual under an individualized family service plan, an individualized education program, or an individualized service plan, required by federal or state law to be performed by public schools, including, but not limited to, individualized education programs, special education services, Individuals with Disabilities Education Improvement Act programs, attention deficit-hyperactivity disorder classrooms, or autism spectrum disorder classrooms.

(8) Nothing in this section shall apply to nongrandfathered plans in the individual and small group markets that are required to include essential health benefits under the Patient Protection and Affordable Care Act or to Medicare supplement, accident-only, specified disease, hospital indemnity, disability income, long-term care, or other limited benefit hospital insurance policies.

(9) A small employer with one hundred (100) or fewer eligible employees that provides or offers a health insurance policy to its employees will offer coverage for the screening, diagnosis and treatment of autism spectrum disorder as provided in this section. The small employer may charge the plan participant with the cost of obtaining the additional coverage.

(10) In the event that any part of this legislation is rendered or declared invalid or unenforceable by a court of competent jurisdiction, such invalidation shall not invalidate the remaining portions thereof, and they shall remain in full force and effect.

HISTORY: Laws, 2015, ch. 415, § 1, eff from and after July 1, 2015.

Editor's Notes — Laws of 2015, ch. 415, § 16 provides:
"SECTION 16. Section 1 of this act shall be codified as a new section in Chapter 9, Title 83, Mississippi Code of 1972 [Section 83-9-26]. Sections 2 through 15 of this act shall be codified as a new chapter in Title 73, Mississippi Code of 1972 [Chapter 75, Sections 73-75-1 through 73-75-27]."

§ 83-9-27. Alcoholism care and treatment; coverage.

Notwithstanding any provision of any policy of accident or sickness insurance as defined by Section 83-9-1, issued on or after January 1, 1975, whenever such policy provides for the reimbursement for loss resulting from sickness, or from bodily injury by accidental means, or both, said reimbursement shall include health service benefits to any insured or any person covered thereunder, on the same basis as other benefits, for care and treatment of alcoholism.

For purposes of Sections 83-9-27 through 83-9-31, alcoholism is defined as the chronic and habitual use of alcoholic beverages by any person to the extent that such person has lost the power of self-control with respect to the use of such beverages.

HISTORY: Laws, 1974, ch. 522, § 1, eff from and after January 1, 1975.

Cross References — Alcoholism, alcohol abuse prevention, control and treatment, see §§ 41-30-1 et seq.

Commitment of alcoholics for treatment, see §§ 41-31-1 et seq.

RESEARCH REFERENCES

ALR.

Clause in life, accident, or health policy excluding or limiting liability in case of insured's use of intoxicants or narcotics. 13 A.L.R.2d 987.

§ 83-9-29. Alcoholism care and treatment; application of law.

The provisions of Sections 83-9-27 through 83-9-31 shall apply only to group policies or group plans of health affording coverage from sickness, or bodily injury by accidental means, or both, or nonprofit health plans corporations regulated by the Mississippi Insurance Commission issued or renewed after January 1, 1975.

The provisions of Sections 83-9-27 through 83-9-31 shall not apply to any plan or policy which is individually underwritten or provided for a specific individual and the members of his family as a nongroup policy.

HISTORY: Laws, 1974, ch. 522, § 2, eff from and after January 1, 1975.

Editor's Notes — Section 83-3-2, effective from and after January 1, 1988, provides that "any reference to Insurance Commission in Title 83 shall mean the Commissioner of Insurance."

§ 83-9-31. Alcoholism care and treatment; limitation of coverage.

The coverage required under Section 83-9-27 shall not exceed One Thousand Dollars ($1,000.00) during any calendar year, and shall extend only to treatment and services rendered by a physician and hospitals licensed by the state wherein the service or hospitalization is rendered.

HISTORY: Laws, 1974, ch. 522, § 3, eff from and after January 1, 1975.

§ 83-9-32. Coverage for medical benefits when dental care provided under physician-supervised anesthesia.

Every hospital, health or medical expenses insurance policy, hospital or medical service contract, health maintenance organization and preferred provider organization that is delivered or issued for delivery in this state and otherwise provides anesthesia benefits shall offer benefits for anesthesia and for associated facility charges when the mental or physical condition of the child or mentally handicapped adult requires dental treatment to be rendered under physician-supervised general anesthesia in a hospital setting, surgical center or dental office. This coverage shall be offered on an optional basis, and each primary insured must accept or reject such coverage in writing and accept responsibility for premium payment.

An insurer may require prior authorization for the anesthesia and associated facility charges for dental care procedures in the same manner that prior authorization is required for treatment of other medical conditions under general anesthesia. An insurer may require review for medical necessity and may limit payment of facility charges to certified facilities in the same manner that medical review is required and payment of facility charges is limited for other services. The benefit provided by this coverage shall be subject to the same annual deductibles or coinsurance established for all other covered benefits within a given policy, plan or contract. Private third-party payers may not reduce or eliminate coverage due to these requirements.

A dentist shall consider the Indications for General Anesthesia as published in the reference manual of the American Academy of Pediatric Dentistry as utilization standards for determining whether performing dental procedures necessary to treat the particular condition or conditions of the patient under general anesthesia constitutes appropriate treatment.

The provisions of this section shall apply to anesthesia services provided by oral and maxillofacial surgeons as permitted by the Mississippi State Board of Dental Examiners.

The provisions of this section shall not apply to treatment rendered for temporal mandibular joint (TMJ) disorders.

HISTORY: Laws, 1999, ch. 528, § 1, eff from and after July 1, 1999.

OPINIONS OF THE ATTORNEY GENERAL

The provisions of Title 83, including Sections 83-9-5 and 83-9-32, which are placed squarely within the jurisdiction of the Department of Insurance, are not applicable to the State and School Employees Health Insurance Plan, which is clearly under the administration of the State and School Employees Health Insurance Management Board under the umbrella of the Department of Finance and Administration. Martinson, Dec. 6, 2002, A.G. Op. #02-0668.

The State and School Employees Health Insurance Plan is not governed by ERISA. Martinson, Dec. 6, 2002, A.G. Op. #02-0668.

§ 83-9-33. Coverage for newly born children.

(1) All individual and group health insurance policies providing coverage on an expense incurred basis and individual and group service or indemnity type contracts issued after January 1, 1980, by an insurer or nonprofit corporation which provides coverage for a family member of the insured or subscriber shall, as to such family members' coverage, also provide that the health insurance benefits applicable for children shall be payable with respect to a newly born child of the insured or subscriber from the moment of birth.

(2) The coverage for newly born children shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects, prematurities and birth abnormalities, but need not include routine well baby care. For purposes of this section, "necessary care and treatment" shall include transportation of the newborn to and from the nearest appropriately staffed and equipped facility for the treatment of such newborn child, when the attending physician certifies that special transportation is necessary to protect the health and safety of the newborn child. Cost of such transportation shall not exceed usual and customary charges up to Two Hundred Dollars ($200.00).

(3) If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or contract may require that notification

of birth of a newly born child must be furnished to the insurer or nonprofit service or indemnity corporation within thirty-one (31) days after the date of birth in order to have the coverage continue beyond such thirty-one day period, and may require that payment of the required premium or fee be made within thirty (30) days after the mailing by the insurer or nonprofit corporation of the notice of premium or fee to the insured.

(4) The requirements of this section shall apply to all insurance policies and subscriber contracts delivered or issued for delivery in this state more than one hundred twenty (120) days after April 4, 1974.

HISTORY: Laws, 1974, ch. 523; Laws, 1979, ch. 435, eff from and after passage (approved March 27, 1979).

Cross References — Policy provisions generally, see § 83-9-5.

JUDICIAL DECISIONS

1. In general.

Section 83-9-33 is not pre-empted by ERISA. Being related to welfare benefit plan, section would be pre-empted if it did not regulate insurance, but it does regulate insurance because it mandates inclusion of certain mandatory minimum coverage in health insurance policies (in instant case, coverage of congenital defects in newly born children). Otherwise stated, statute was specifically directed and limited to insurance industry, has effect of spreading policy holder's risk, is integral part of policy relationship between insurer and insured, and by itself does not conflict with civil enforcement provisions of ERISA. Walters v. Pan American Life Ins. Co., 800 F. Supp. 436, 1990 U.S. Dist. LEXIS 20030 (S.D. Miss. 1990).

RESEARCH REFERENCES

ALR.

Coverage of artificial insemination procedures or other infertility treatments by health, sickness, or hospitalization insurance. 80 A.L.R.4th 1059.

Law Reviews.

1979 Mississippi Supreme Court Review: Insurance. 50 Miss. L. J. 813.

§ 83-9-34. Child immunizations; optional coverage; written acceptance or rejection; application of section.

(1) In this section, "health benefit plan" means a plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident or sickness and that is offered by any insurance company, group hospital service corporation or health maintenance organization that delivers or issues for delivery an individual, group, blanket or franchise insurance policy or insurance agreement, a group hospital service contract or an evidence of coverage or, to the extent permitted, by the Employee Retirement Income Security Act of 1974 (29 USCS Section 1001 et seq.), by a multiple employer welfare arrangement as defined by Section 3, Employee Retirement Income Security Act of 1974 (29 USCS Section 1002) or any other analogous benefit arrangement. The term does not include:

(a) A plan that provides coverage:

(i) Only for a specified disease;

(ii) Only for accidental death or dismemberment;

(iii) For wages or payments in lieu of wages for a period during which an employee is absent from work because of sickness or injury; or

(iv) As a supplement to liability insurance.

(b) A Medicare supplemental policy as defined by Section 1882 (g)(1), Social Security Act (42 USCS Section 1395ss);

(c) Workers' compensation insurance coverage;

(d) Medical payment insurance issued as part of a motor vehicle insurance policy;

(e) A long-term care policy, including a nursing home fixed indemnity policy, unless the commissioner determines that the policy provides benefit coverage so comprehensive that the policy meets the definition of a health benefit plan; or

(f) A hospital indemnity only policy.

(2) A health benefit plan that provides benefits for a family member of the insured shall provide an option for the insured to elect coverage for each newly born child of the insured, from birth through the date the child is twenty-four (24) months of age, for:

(a) Immunization against:

(i) Diphtheria;

(ii) Hepatitis B;

(iii) Measles;

(iv) Mumps;

(v) Pertussis;

(vi) Polio;

(vii) Rubella;

(viii) Tetanus;

(ix) Varicella; and

(x) Hemophilus Influenza B (HIB).

(b) Any other immunization that the Commissioner of Insurance determines to be required by law for the child.

(c) The coverage shall be offered on an optional basis, and each primary insured must accept or reject such coverage in writing and accept responsibility for premium payment.

(3) The benefits required to be offered under subsection (2) of this section may not be made subject to a deductible, copayment or coinsurance requirement.

(4) This section applies only to a health benefit plan that is delivered, issued for delivery or renewed on or after January 1, 1999. A health benefit plan that is delivered, issued for delivery or renewed before January 1, 1999, is governed by the law as it existed immediately before January 1, 1999, and that law is continued in effect for this purpose.

HISTORY: Laws, 1998, ch. 483, § 2, eff from and after January 1, 1999.

§ 83-9-35. Replacement of group or blanket health and accident policy or plan; succeeding carrier's plan to continue certain benefits and provisions.

(1) This section shall apply to any health benefit plan that provides coverage to two (2) or more employees of an employer in this state if any of the following conditions are satisfied:

(a) Any portion of the premium or benefits is paid by or on behalf of the employer;

(b) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the employer for any portion of the premium; or

(c) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Sections 162, 125 or 106 of the United States Internal Revenue Code.

(2) This section shall not apply to a health benefit plan which is issued in good faith with no knowledge or intent that the plan will, at the time of issuance or thereafter, satisfy one or more of the conditions set forth in subsection (1), and the insurer has certified to the Department of Insurance that the policy form:

(a) Is not designed to be an employer-provided insurance.

(b) Is not intended to be an employer-provided insurance.

(c) Will not be advertised or marketed as employer-provided insurance.

(d) Will not be issued if the insurer knows that the policy will meet one (1) or more of the conditions set forth in subsection (1).

(3) This section shall not apply to an employer whose only role is collecting through payroll deductions the premiums of individual policies on behalf of employees.

(4) "Health benefit plan" means any group hospital or medical policy or group certificate delivered or issued for delivery in this state by an insurer; a nonprofit hospital, medical and surgical service corporation; a health maintenance organization; a fully insured multiple employer welfare arrangement; or any combination of these, except hospital daily indemnity plans, specified disease only policies, or other limited, supplemental benefit insurance policies.

(5) Whenever a health benefit plan of one carrier replaces a health benefit plan of similar benefits of another carrier:

(a) The prior carrier shall remain liable only to the extent of its accrued liabilities. The position of the prior carrier shall be the same whether the group policyholder or other entity secures replacement coverage from a new carrier, or a self-insurer, or foregoes the provision of coverage.

(b) Each person who was validly covered under the prior health plan, who is eligible for coverage in accordance with the succeeding carrier's plan of benefits, with respect to classes eligible, shall be covered by that carrier's plan of benefits. No previously covered person shall be considered ineligible for coverage solely because of his health condition or claims experience.

(c) The succeeding carrier, in determining whether a preexisting condition provision applies to an eligible employee or dependent, shall credit the time the person was covered under the prior plan if the previous coverage was continuous to a date not more than thirty (30) days prior to the effective date of the new coverage.

(d) The succeeding carrier, in applying any deductibles or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions, the credit shall apply for the same or overlapping benefit periods and shall be given for expenses actually incurred and applied against the deductible provisions of the prior carrier's plan during the ninety (90) days preceding the effective date of the succeeding carrier's plan, but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to a similar deductible provision.

(e) Whenever a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request, the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this paragraph, benefits of the prior plan shall be determined in accordance with all of the definitions, conditions and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage was not replaced by the succeeding carrier.

(f) This section shall be applicable to any coverage offered and maintained as a result of membership or connection with any association or organization which exists for the purpose of offering health insurance to its members, and shall further be applicable to any health insurance policy or plan which is not made available to the general public on an individual basis with the exception of any State of Mississippi comprehensive health association.

HISTORY: Laws, 1982, ch. 380; Laws, 1991, ch. 571, § 1; Laws, 1993, ch. 492, § 1, eff from and after July 1, 1993.

Federal Aspects — Sections 106, 125 and 162 of the Internal Revenue Code are codified as 26 USCS §§ 106, 125 and 162.

JUDICIAL DECISIONS

1. In general.

Employee claim for insurance benefits under employer's group health policy, after insurer had denied coverage for surgery performed to repair pre-existing birth defect of employee's son, conflicted with civil enforcement provision of ERISA limiting employee to remedies available under ERISA's civil enforcement scheme. Walters v. Pan American Life Ins. Co., 800 F. Supp. 436, 1990 U.S. Dist. LEXIS 20030 (S.D. Miss. 1990).

Replacement insurer, under group health policy, was not required to provide coverage for dependent of insured who suffered from multiple sclerosis where disease was pre-existing condition relative to replacement insurer's coverage and prior insurer's coverage for this illness had apparently run out at time of replacement coverage. Freeman v. Mowdy, 743 F. Supp. 475, 1990 U.S. Dist. LEXIS 10388 (S.D. Miss. 1990).

§ 83-9-36. Process by which prescribing practitioner may request override of restriction on medication restricted for use by insurer step therapy or fail-first protocol; circumstances under which insurer to grant override.

(1) When medications for the treatment of any medical condition are restricted for use by an insurer by a step therapy or fail-first protocol, the prescribing practitioner shall have access to a clear and convenient process to expeditiously request an override of that restriction from the insurer. An override of that restriction shall be expeditiously granted by the insurer under the following circumstances:

(a) The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred treatment required under step therapy or fail-first protocol has been ineffective in the treatment of the insured's disease or medical condition; or

(b) Based on sound clinical evidence or medical and scientific evidence:

(i) The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or

(ii) The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to the insured.

(2) The duration of any step therapy or fail-first protocol shall not be longer than a period of thirty (30) days when the treatment is deemed clinically ineffective by the prescribing practitioner. When the prescribing practitioner can demonstrate, through sound clinical evidence, that the originally prescribed medication is likely to require more than thirty (30) days to provide any relief or an amelioration to the insured, the step therapy or fail-first protocol may be extended up to seven (7) additional days.

(3) As used in this section:

(a) "Insurer" means any hospital, health, or medical expense insurance policy, hospital or medical service contract, employee welfare benefit plan, contract or agreement with a health maintenance organization or a preferred provider organization, health and accident insurance policy, or any other insurance contract of this type, including a group insurance plan. However, the term "insurer" does not include a preferred provider organization that is only a network of providers and does not define health care benefits for the purpose of coverage under a health care benefits plan.

(b) "Practitioner" has the same meaning as defined in Section 73-21-73.

HISTORY: Laws, 2011, ch. 500, § 1, eff from and after Jan. 1, 2012.

COVERAGE FOR TREATMENT OF MENTAL ILLNESS, TEMPOROMANDIBULAR JOINT DISORDER AND CRANIOMANDIBULAR DISORDER

Sec.
83-9-37. Definitions.
83-9-39. Coverage.
83-9-40. Repealed.
83-9-41. Mental illness benefits.
83-9-43. Nondiscrimination.
83-9-45. Coverage and benefits for treatment of temporomandibular joint disorder and craniomandibular disorder.
83-9-46. Diabetes treatment; coverage; service providers; enforcement; application to other policies.

§ 83-9-37. Definitions.

As used in Sections 83-9-37 through 83-9-43, Mississippi Code of 1972:

(a) "Alternative delivery system" means a health maintenance organization (HMO), preferred provider organization (PPO), exclusive provider organization (EPO), individual practice association (IPA), medical staff hospital organization (MESH), physician hospital organization (PHO), and any other plan or organization which provides health care services through a mechanism other than insurance and is regulated by the State of Mississippi.

(b) "Covered benefits" means the health care services or treatment available to an insured party under a health insurance policy for which the insurer will pay part or all of the costs.

(c) "Hospital" means a facility licensed as a hospital by the Mississippi Department of Health.

(d) "Health service provider" means a physician or psychologist who is authorized by the facility in which services are delivered to provide mental health services in an inpatient or outpatient setting, within his or her scope of licensure.

(e) "Inpatient services" means therapeutic services which are available twenty-four (24) hours a day in a hospital or other treatment facility licensed by the State of Mississippi.

(f) "Mental illness" means any psychiatric disease identified in the current edition of The International Classification of Diseases or The American Psychiatric Association Diagnostic and Statistical Manual.

(g) "Outpatient services" means therapeutic services which are provided to a patient according to an individualized treatment plan which does not require the patient's full-time confinement to a hospital or other treatment facility licensed by the State of Mississippi. The term "outpatient services" refers to services which may be provided in a hospital, an outpatient treatment facility or other appropriate setting licensed by the State of Mississippi.

(h) "Outpatient treatment facility" means (i) a clinic or other similar location which is certified by the State of Mississippi as a qualified provider of outpatient services for the treatment of mental illness or (ii) the office of a health service provider.

(i) "Partial hospitalization" means inpatient treatment, other than full twenty-four-hour programs, in a treatment facility licensed by the State of Mississippi; the term includes day, night and weekend treatment programs.

(j) "Physician" means a physician licensed by the State of Mississippi to practice therein.

(k) "Psychologist" means a psychologist licensed by the State of Mississippi to practice therein.

HISTORY: Laws, 1991, ch. 570, § 1; reenacted without change by Laws, 1994, ch. 354, § 1, eff from and after July 1, 1994.

Editor's Notes — Laws of 1991, ch. 570, § 6, effective from and after July 1, 1991, which enacted Sections 83-9-37 through 83-9-43, provided that the act was to stand repealed from and after July 1, 1994. Subsequently, Laws of 1994, ch. 354, § 6, amended Laws of 1991, ch. 570, § 6, so as to delete the provision for the repeal of this section.

RESEARCH REFERENCES

Practice References.
Business Law Monographs, Volume IN1 —Business Uses of Life Insurance (Matthew Bender Elite Products).

§ 83-9-39. Coverage.

(1)(a) Except as otherwise provided herein, all alternative delivery systems and all group health insurance policies, plans or programs regulated by the State of Mississippi shall provide covered benefits for the treatment of mental illness, except for policies which only provide coverage for specified diseases and other limited benefit health insurance policies and negotiated labor contracts.

(b) Health insurance policies, plans or programs of any employer of one hundred (100) or fewer eligible employees and all individual health insurance policies which are regulated by the State of Mississippi which do not currently offer benefits for treatment of mental illness shall offer covered benefits for the treatment of mental illness, which must include the treatment of mental illness by community mental health centers operated by a regional commission established under Section 41-19-33 or by a public or private entity under contract with a regional commission to operate the center, except for policies which only provide coverage for specified diseases and other limited benefit health insurance policies and negotiated labor contracts.

(c) Alternative delivery systems and group health insurance policies, plans or programs regulated by the State of Mississippi shall not deny any community mental health center or contract entity described in paragraph (b) of this subsection the right to participate as a contract provider if the community mental health center or contract entity agrees to provide the mental health services that meet the terms of requirements set forth by the insurer under the policy or plan and agrees to the terms of reimbursement set forth by the insurer. Certification/licensure of all mental health providers by the Board of Mental Health in accordance with Section 41-4-7(r) shall be recognized by the insurer and shall not be used as a reason to deny any mental health provider the right to participate as a contract provider.

(2) Covered benefits for inpatient treatment of mental illness in insurance policies and other contracts subject to Sections 83-9-37 through 83-9-43 shall be limited to inpatient services certified as necessary by a health service provider.

(3) Covered benefits for outpatient treatment of mental illness in insurance policies and other contracts subject to Sections 83-9-37 through 83-9-43 shall be limited to outpatient services certified as necessary by a health service provider.

(4) Before an insured party may qualify to receive benefits under Sections 83-9-37 through 83-9-43, a health service provider shall certify that the individual is suffering from mental illness and refer the individual for the appropriate treatment.

(5) All mental illness, treatment or services with respect to such treatment eligible for health insurance coverage shall be subject to professional utilization and peer review procedures.

(6) The provisions of this section shall apply only to alternative delivery systems and individual and group health insurance policies, plans or programs issued or renewed after July 1, 1991.

(7) The exclusion period for coverage of a preexisting mental condition shall be the same period of time as that for other medical illnesses covered under the same plan, program or contract.

HISTORY: Laws, 1991, ch. 570, § 2; reenacted without change by Laws, 1994, ch. 354, § 2; Laws, 2001, ch. 533, § 1; Laws, 2014, ch. 308, § 1, eff from and after July 1, 2014; Laws, 2022, ch. 447, § 1, eff from and after July 1, 2022.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "paragraph (b) of this subsection" for "paragraph (b) of this section" in the first sentence of (1)(c). The Joint Committee ratified the correction at its August 10, 2022, meeting.

Editor's Notes — Laws of 1991, ch. 570, § 6, effective from and after July 1, 1991, which enacted Sections 83-9-37 through 83-9-43, provided that the act was to stand repealed from and after July 1, 1994. Subsequently, Laws of 1994, ch. 354, § 6, amended Laws of 1991, ch. 570, § 6, so as to delete the provision for the repeal of this section.

Section 83-9-40 referred to in (1)(a), was repealed by Laws of 2014, ch. 308, § 3 repealed effective July 1, 2014.

Laws of 2014, ch. 308, § 4, provides:

"SECTION 4. This act shall take effect and be in force from and after July 1, 2014, and shall apply only to alternative delivery systems and individual and group health insurance policies, plans or programs issued or renewed on or after July 1, 2014."

Amendment Notes — The 2022 amendment, in (1), inserted "which must include the treatment…commission to operate the center" in (b), and added (c).

§ 83-9-40. Repealed.

Repealed by Laws of 2014, ch. 308, § 3, effective from and July 1, 2014. § 83-9-40. [Laws, 2001, ch. 533, § 3, eff from and after Jan. 1, 2002.]

Editor's Notes — Former § 83-9-40 provided the formula for determining which health insurance policies were required to provide covered benefits for the treatment of mental illness.

§ 83-9-41. Mental illness benefits.

(1) Covered benefits for services in this section shall be limited to coverage of treatment of clinically significant mental illness.

(2) Treatment under this section shall be covered for a minimum of thirty (30) days per year for inpatient services, a minimum of sixty (60) days per year for partial hospitalization, and a minimum of fifty-two (52) outpatient visits per year.

(3) The rate of payment for inpatient services, outpatient services, and partial hospitalization shall be the same as provided for any other condition.

HISTORY: Laws, 1991, ch. 570, § 3; reenacted without change by Laws, 1994, ch. 354, § 3; Laws, 2001, ch. 533, § 2; Laws, 2014, ch. 308, § 2, eff from and after July 1, 2014.

Editor's Notes — Laws of 1991, ch. 570, § 6, effective from and after July 1, 1991, which enacted Sections 83-9-37 through 83-9-43, provided that the act was to stand repealed from and after July 1, 1994. Subsequently, Laws of 1994, ch. 354, § 6, amended Laws of 1991, ch. 570, § 6, so as to delete the provision for the repeal of this section.

Laws of 2014, ch. 308, § 4, provides:

"SECTION 4. This act shall take effect and be in force from and after July 1, 2014, and shall apply only to alternative delivery systems and individual and group health insurance policies, plans or programs issued or renewed on or after July 1, 2014."

Cross References — Allowance of deductible or co-payment plans and annual and lifetime limits on benefit payments, see § 83-9-43.

§ 83-9-43. Nondiscrimination.

Methods of determining levels of payment or reimbursement for services or for the type of facility charges eligible for payment or reimbursement pursuant to Sections 83-9-37 through 83-9-43 shall be consistent with those for medical illnesses in general and shall take into consideration customary charges for those services. Deductible or co-payment plans, methods of determination, and limits on total amounts payable to an individual in a calendar year or lifetime payment limits may be applied to benefits paid to or on behalf of patients during the course of treatment as described in Sections 83-9-37 through 83-9-43, but in any case shall not be less favorable than those applied to medical illnesses generally in each policy or contract, except as provided under Section 83-9-41, Mississippi Code of 1972.

HISTORY: Laws, 1991, ch. 570, § 5; reenacted without change by Laws, 1994, ch. 354, § 4, eff from and after July 1, 1994.

Editor's Notes — Laws of 1991, ch. 570, § 6, effective from and after July 1, 1991, which enacted Sections 83-9-37 through 83-9-43, provided that the act was to stand repealed from and after July 1, 1994. Subsequently, Laws of 1994, ch. 354, § 6, amended Laws of 1991, ch. 570, § 6, so as to delete the provision for the repeal of this section.

§ 83-9-45. Coverage and benefits for treatment of temporomandibular joint disorder and craniomandibular disorder.

Except for policies which only provide coverage for specified diseases and other limited benefit health insurance policies, no policy or certificate of health, medical, hospitalization or accident and sickness insurance and no subscriber contract provided by a nonprofit health service plan corporation or health maintenance organization shall be issued, renewed, continued, issued for delivery or executed in this state after July 1, 1991, unless the policy, plan or contract specifically offers coverage for diagnostic and surgical treatment of temporomandibular joint disorder and craniomandibular disorder. Coverage for diagnostic services and surgery shall be the same as that for treatment to any other joint in the body and shall apply if the treatment is administered or prescribed by a physician or dentist. The minimum lifetime coverage for temporomandibular joint disorder and craniomandibular treatment shall be no less than Five Thousand Dollars ($5,000.00).

HISTORY: Laws, 1991, ch. 570, § 4; reenacted without change by Laws, 1994, ch. 354, § 5, eff from and after July 1, 1994.

Editor's Notes — Laws of 1991, ch. 570, § 6, effective from and after July 1, 1991, which enacted Sections 83-9-37 through 83-9-43, provided that the act was to stand repealed from and after July 1, 1994. Subsequently, Laws of 1994, ch. 354, § 6, amended Laws of 1991, ch. 570, § 6, so as to delete the provision for the repeal of this section.

RESEARCH REFERENCES

ALR.

Coverage under medical and health insurance plans for services performed by dentist, oral surgeons, and orthodontists. 43 A.L.R.5th 657.

§ 83-9-46. Diabetes treatment; coverage; service providers; enforcement; application to other policies.

(1) Except as otherwise provided herein, from and after January 1, 1999, all individual and group health insurance policies or plans, pooled risk policies and all other forms of managed/capitated care plans or policies regulated by the State of Mississippi shall offer coverage for diabetes treatments, including, but not limited to, equipment, supplies used in connection with the monitoring of blood glucose and insulin administration and self-management training/

education and medical nutrition therapy in an outpatient, inpatient or home health setting. An amount of coverage not to exceed Two Hundred Fifty Dollars ($250.00) shall be offered annually for self-management training/education and medical nutrition therapy under this section. The coverage shall be offered on an optional basis, and each primary insured must accept or reject such coverage in writing and accept responsibility for premium payment. The coverage shall include treatment of all forms of diabetes, including, but not limited to, Type I, Type II, Gestational and all secondary forms of diabetes regardless of mode of treatment if such treatment is prescribed by a health care professional legally authorized to prescribe such treatment and regardless of the age of onset or duration of the disease. Such health insurance plans and policies shall not reduce, eliminate or delay coverage due to the requirements of this section.

(2) The services provided in an outpatient, inpatient or home health setting shall be provided by a Certified Diabetes Educator (CDE), who is appropriately certified, licensed or registered to practice in the State of Mississippi. Medical nutrition therapy shall be provided by a Registered Dietician (RD) appropriately licensed to practice in the State of Mississippi. All services shall be based on nationally recognized standards including, but not limited to, the American Diabetes Association Practice Guidelines.

(3) The benefits provided in this section shall be subject to the same annual deductibles or coinsurance established for all other covered benefits within a given policy.

(4) The Commissioner of Insurance shall enforce the provisions of this section.

(5) Nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care or other limited benefit health insurance policies.

HISTORY: Laws, 1998, ch. 483, § 1, eff from and after January 1, 1999.

NOTICE OF PAYMENT FOR SERVICES MADE DIRECTLY TO PATIENT

Sec.

83-9-47.	Third-party payors required to notify health care providers of payment for services made directly to patient.
83-9-49.	Limit on exclusion of preexisting condition from health and accident insurance coverage; definition of preexisting condition; exceptions.
83-9-51.	Group policy defined; election to continue coverage after employment termination; continuation of coverage by dependent spouse or child; exclusions; payment; termination of coverage; notice.
83-9-53.	Authorization to establish rules and regulations.

§ 83-9-47. Third-party payors required to notify health care providers of payment for services made directly to patient.

(1) As used in this section, the following terms shall be defined as follows:

(a) "Third-party payor" means any insurer, nonprofit hospital service plan, health care service plan, health maintenance organization, self-insurer or any person or other entity which provides payment for medical and related services.

(b) "Health care provider" means a physician, optometrist, chiropractor, dentist, podiatrist, pharmacist, psychologist or hospital licensed by the State of Mississippi.

(c) "Patient" means any natural person who has received medical care or services from any medical care provider within the State of Mississippi.

(2) Any third-party payor who pays a patient or policyholder on behalf of a patient directly for medical care or services rendered by a health care provider shall provide information concerning the amount, date and nature of any such payment to the provider of services. The information may be provided by telephone, facsimile or by mailing a copy of the "explanation of benefits" to the provider. If the information is provided by sending a copy of the "explanation of benefits" to the provider, then the third-party payor may require that the reasonable cost of producing and mailing the information be paid by the provider. The requirements of this subsection shall not apply to the following: a fixed-indemnity policy, a limited benefit health insurance policy, medical payment coverage or personal injury protection coverage in a motor vehicle policy, coverage issued as a supplement to liability insurance or workers' compensation.

HISTORY: Laws, 1991, ch. 474, § 1, eff from and after July 1, 1991.

RESEARCH REFERENCES

Practice References.
Business Law Monographs, Volume IN1—Business Uses of Life Insurance (Matthew Bender Elite Products).

§ 83-9-49. Limit on exclusion of preexisting condition from health and accident insurance coverage; definition of preexisting condition; exceptions.

(1) Any group hospital, health or medical expense insurance policy, hospital or medical service contract, health and accident insurance policy or any other insurance contract of this type which is delivered or issued for delivery in this state on or after January 1, 1994, shall not deny, exclude or limit benefits for a covered individual for losses due to a preexisting condition incurred more than twelve (12) months following the effective date of the individual's coverage. Any group policy, contract or plan subject to this section shall not contain a definition of a preexisting condition more restrictive than the following:

(a) A condition that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;

(b) A condition for which medical advice, diagnosis, care or treatment was recommended or received during the six (6) months immediately preceding the effective date of coverage.

(2) Any individual hospital, health or medical expense insurance policy, hospital or medical service contract, health and accident insurance policy or any other insurance contract of this type which is delivered or issued for delivery in this state on or after January 1, 1994, shall not deny, exclude or limit benefits for a covered individual for losses due to a preexisting condition incurred more than twelve (12) months following the effective date of the individual's coverage. Any individual policy, contract or plan subject to this section shall not contain a definition of a preexisting condition more restrictive than the following:

(a) A condition that would have caused an ordinary prudent person to seek medical advice, diagnosis, care or treatment during the twelve (12) months immediately preceding the effective date of coverage;

(b) A condition for which medical advice, diagnosis, care or treatment was recommended or received during the twelve (12) months immediately preceding the effective date of coverage;

(c) A pregnancy existing on the effective date of coverage.

(3) This section shall not apply to hospital daily indemnity plans, specified disease only policies, or other limited, supplemental benefit insurance policies.

HISTORY: Laws, 1993, ch. 492, § 2; Laws, 1997, ch. 340, § 1, eff from and after July 1, 1997.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 608, 625.

§ 83-9-51. Group policy defined; election to continue coverage after employment termination; continuation of coverage by dependent spouse or child; exclusions; payment; termination of coverage; notice.

(1) "Group policy" means a group accident and health insurance policy or group certificate delivered or issued for delivery in this state by an insurer; a nonprofit hospital, medical and surgical service corporation; a health maintenance organization; a fully insured multiple employer welfare arrangement; or any combination thereof.

(2) A group policy delivered or issued for delivery in this state which insures employees or members, and their eligible dependents, if they have elected to include them, for hospital, surgical or major medical insurance on an expense incurred or service basis, other than hospital daily indemnity plans, specified disease only policies, or other limited, supplemental benefit insurance policies, shall provide that employees or members whose insurance for these types of coverage under the group policy would otherwise terminate because of termination of active employment or membership, or termination of membership in the eligible class or classes under the policy, shall be entitled to

continue their hospital, surgical and medical insurance under that group policy, for themselves and their eligible dependents with respect to whom they were insured on the date of termination, subject to all of the group policy's terms and conditions applicable to those forms of insurance and to the conditions specified in this section. The terms and conditions set forth in this section are intended as minimum requirements and shall not be construed to impose additional or different requirements upon those group hospital, surgical or major medical plans already in force, or hereafter placed into effect, that provide continuation benefits equal to or better than those required in this section.

(3) Continuation shall only be available to an employee or member or an eligible dependent who has been continuously insured under the group policy, or for similar benefits under any other group policy that it replaced, during the period of three (3) consecutive months immediately before the date of termination. The continued policy must cover all dependents covered under the group policy. A dependent spouse of an employee or member may elect continuation of dependent spouse and dependent child coverage for a period of coverage not to exceed twelve (12) months after: (a) the date of the death of the employee or member; (b) the date of the spouse's divorce from the employee or member; or (c) the date that the employee or member becomes entitled to Medicare benefits as provided under Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

A dependent child of an employee or member may elect continuation of his or her coverage for a period not to exceed twelve (12) months after the child ceases to be an eligible dependent of the employee or member.

(4) Continuation shall not be available for any person who is or could be covered by any other arrangement of hospital, surgical or medical coverage for individuals in a group, whether insured or uninsured, within thirty-one (31) days immediately following the date of termination, or whose insurance terminated because of fraud or because he failed to pay any required contribution for the insurance, or who is eligible for continuation under the provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) or who becomes entitled to Medicare benefits.

(5) Continuation shall not include dental, vision care or any other benefits provided under the group policy in addition to its hospital, surgical or major medical benefits.

(6) An employee or member or an eligible dependent electing continuation shall pay to the insurer, in advance, the amount of contribution required, which shall not be more than the full group rate for the instance applicable to the employee or member or an eligible dependent under the group policy on the due date of each payment. The employee or member or an eligible dependent shall not be required to pay the amount of the contribution less often than monthly. In order to be eligible for continuation of coverage, the employee or member or an eligible dependent shall make a written election of continuation on a form furnished by the insurer and pay the first contribution, in advance, to the insurer on or before the date on which the employee's or member's or

eligible dependent's insurance would otherwise terminate except as provided herein.

(7) Continuation of insurance under the group policy for any person shall terminate on the earliest of the following dates:

(a) The date twelve (12) months after the date the employee's or member's insurance under the policy would otherwise have terminated because of termination of employment or membership.

(b) The date ending the period for which the employee or member or dependent last makes his required contribution, if he discontinues his contributions.

(c) The date the employee or member or dependent becomes or is eligible to become covered for similar benefits under any arrangement of coverage for individuals in a group, whether insured or uninsured.

(d) The date on which the group policy is terminated or, in the case of a multiple employer plan, the date his employer terminates participation under the group master policy.

(e) The date on which an enrolled member of a health maintenance organization legally resides outside the service area of the organization.

(f) The date the surviving spouse or former spouse of the employee or member remarries and becomes covered under a group health plan that does not exclude coverage for preexisting conditions.

(g) The date the employee or member or dependent becomes entitled to benefits under Medicare.

(8) A notification of the continuation privilege shall be included in each certificate of coverage.

(9) In the event of the employee's or member's death, the insurer shall provide notice of the continuation privilege within fourteen (14) days of the death to the person who is eligible to elect continuation. Such person has thirty (30) days after the notice to elect continuation.

(10) In the event that a dependent child of the employee or member ceases to be an eligible dependent, the insurer shall provide notice of the continuation privilege to the child within fourteen (14) days after the employee or member notifies the insurer of the child's ineligibility. The child has thirty (30) days after the notice to elect continuation of coverage.

(11) In the event of the employee's or member's divorce from his or her dependent spouse, the insurer shall provide notice of the continuation privilege to the spouse within fourteen (14) days after the employee or member notifies the insurer of the divorce. The spouse has thirty (30) days after the notice to elect continuation of coverage.

HISTORY: Laws, 1993, ch. 492, § 3; Laws, 1995, ch. 541, § 1, eff from and after July 1, 1995.

Federal Aspects — The Consolidated Omnibus Budget Reconciliation Act of 1987 (COBRA) is codified as 29 USCS §§ 1161 et seq. Title XVIII of the Social Security Amendments of 1965, see 42 USCS §§ 1395 et seq.

RESEARCH REFERENCES

ALR.
Group insurance: construction, application, and effect of policy provision extending conversion privilege to employee after termination of employment. 32 A.L.R.4th 1037.

Am. Jur.
44A Am. Jur. 2d, Insurance §§ 1842-1856.

§ 83-9-53. Authorization to establish rules and regulations.

The Commissioner of Insurance may establish such rules and regulations as may be necessary or desirable to carry out Sections 83-9-47 through 83-9-53.

HISTORY: Laws, 1993, ch. 492, § 4, eff from and after July 1, 1993.

MEDICARE SUPPLEMENT INSURANCE

Sec.

83-9-101. Definitions.
83-9-102. Applicability of provisions.
83-9-103. Regulations to be issued by commissioner.
83-9-105. Adoption of minimum standards for benefits; claim payments, etc.
83-9-106. Minimum reserves for accident and health insurance companies.
83-9-107. Minimum standards for loss ratios.
83-9-108. Mammography; optional coverage; written acceptance or rejection; application of section.
83-9-109. Outline of coverage.
83-9-110. Review and approval of advertising by commissioner.
83-9-111. Right to return policy or certificate.
83-9-112. Penalty for issuers violating statutory provisions.
83-9-113. Regulations subject to administrative procedures law.
83-9-115. Effect of partial invalidity of provisions.

§ 83-9-101. Definitions.

As used in Sections 83-9-101 through 83-9-115:

(a) "Applicant" means:

(i) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(ii) In the case of a group Medicare supplement policy, the proposed certificate holder.

(b) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplemental policy.

(c) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(d) "Commissioner" means the Commissioner of Insurance of this state.

(e) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

(f) "Medicare supplement policy" means a group or individual policy of accident and health insurance, or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, or an issued policy under a demonstration project specified in 42 USCS Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

(g) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(h) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

HISTORY: Laws, 1981, ch. 433, § 1; Laws, 1992, ch. 337 § 1; Laws, 1996, ch. 321, § 1, eff from and after passage (approved March 17, 1996).

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "83-9-115" for "83-9-113" in the introductory paragraph and substituted "42 USCS Section 1395ss(g)(1)" for "42 USCS 1395(g)(1)" in (f). The Joint Committee ratified the correction at its August 10, 2022, meeting.

Editor's Notes — Section 8 of Chapter 433, Laws of 1981, provides as follows:

"SECTION 8. This act shall be effective on October 1, 1981, and shall apply to policies and subscriber contracts delivered or issued for delivery in this state after such later date as is specified in the regulations adopted by the commissioner."

Federal Aspects — Title XVIII of the Social Security Amendments of 1965, see 42 USCS §§ 1395 et seq.

RESEARCH REFERENCES

Am. Jur.

70A Am. Jur. 2d, Social Security and Medicare §§ 2045, 2063, 2112, 2439.

CJS.

81 C.J.S., Social Security and Public Welfare §§ 231-246.

Practice References.

Business Law Monographs, Volume IN1 —Business Uses of Life Insurance (Matthew Bender Elite Products).

§ 83-9-102. Applicability of provisions.

(1) Sections 83-9-101 through 83-9-115 shall apply to:

(a) All Medicare supplement policies delivered or issued for delivery in this state on or after April 20, 1992, and

(b) All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

(2) Sections 83-9-101 through 83-9-115 shall not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(3) Except as otherwise specifically provided in Section 83-9-109(4), Sections 83-9-101 through 83-9-115 are not intended to prohibit or apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons which policies are not marketed or held to be Medicare supplement policies or benefit plans.

HISTORY: Laws, 1992, ch. 337 § 2; Laws, 1996, ch. 321, § 2, eff from and after passage (approved March 17, 1996).

§ 83-9-103. Regulations to be issued by commissioner.

(1) The commissioner shall adopt reasonable regulations to establish specific standards for policy provisions of Medicare supplement policies and certificates. Such standards shall be in addition to and in accordance with applicable laws of this state including Sections 83-9-1 through 83-9-21, Mississippi Code of 1972. No requirement of the insurance code relating to minimum required policy benefits, other than the minimum standards contained in Sections 83-9-101 through 83-9-115, shall apply to Medicare supplement policies and certificates. The standards may cover, but not be limited to:

(a) Terms of renewability;
(b) Initial and subsequent conditions of eligibility;
(c) Nonduplication of coverage;
(d) Probationary periods;
(e) Benefit limitations, exceptions and reductions;
(f) Elimination periods;
(g) Requirements for replacement;
(h) Recurrent conditions; and
(i) Definitions of terms.

(2) The commissioner may adopt reasonable regulations that specify prohibited policy provisions not otherwise specifically authorized by statute which, in the opinion of the commissioner, are unjust, unfair or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement policy or certificate.

(3) Notwithstanding any other provisions of law, a Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(4) The commissioner may adopt such reasonable regulations as are necessary to conform Medicare supplement policies and certificates to the requirements of federal law and regulations promulgated thereunder, including but not limited to:

(a) Requiring refunds or credits if the policies or certificates do not meet loss ratio requirements;

(b) Establishing a uniform methodology for calculating and reporting loss ratios;

(c) Assuring public access to policies, premiums and loss ratio information of issuers of Medicare supplement insurance;

(d) Establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases; and

(e) Establishing a policy for holding public hearings prior to approval of premium increases.

(5) No Medicare supplement policy or certificate in force in the State shall contain benefits that duplicate benefits provided by Medicare.

HISTORY: Laws, 1981, ch. 433, § 2; Laws, 1992, ch. 337 § 3, eff from and after passage (approved April 20, 1992).

Editor's Notes — Section 8 of Chapter 433, Laws of 1981, provides as follows: "SECTION 8. This act shall be effective on October 1, 1981, and shall apply to policies and subscriber contracts delivered or issued for delivery in this state after such later date as is specified in the regulations adopted by the commissioner."

RESEARCH REFERENCES

ALR.
Validity, construction, and application of 42 USCS § 1320c-5, providing for obligations of health care practitioners and providers of health care services under medicare. 102 A.L.R. Fed. 473.

Am. Jur.
70A Am. Jur. 2d, Social Security and Medicare §§ 2045, 2063, 2112, 2439.

CJS.
81 C.J.S., Social Security and Public Welfare §§ 231-246.

§ 83-9-105. Adoption of minimum standards for benefits; claim payments, etc.

The commissioner shall adopt reasonable regulations to establish minimum standards for benefits, claims payment, marketing practices and compensation arrangements and reporting practices for Medicare supplement policies and certificates.

HISTORY: Laws, 1981, ch. 433, § 3; Laws, 1992, ch. 337 § 4, eff from and after passage (approved April 20, 1992).

Editor's Notes — Section 8 of Chapter 433, Laws of 1981, provides as follows: "SECTION 8. This act shall be effective on October 1, 1981, and shall apply to policies and subscriber contracts delivered or issued for delivery in this state after such later date as is specified in the regulations adopted by the commissioner."

RESEARCH REFERENCES

Am. Jur.
70A Am. Jur. 2d, Social Security and Medicare §§ 2045, 2063, 2112, 2439.

CJS.
81 C.J.S., Social Security and Public Welfare §§ 231-246.

§ 83-9-106. Minimum reserves for accident and health insurance companies.

The Commissioner of Insurance shall establish regulations setting forth standards to provide minimum reserves for accident and health insurance companies, including nonprofit hospital, medical and surgical service corporations.

HISTORY: Laws, 1992, ch. 426, § 1, eff from and after July 1, 1992.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 28, 38.

§ 83-9-107. Minimum standards for loss ratios.

Medicare supplement policies shall return to policyholders benefits which are reasonable in relation to the premium charged. The commissioner shall issue reasonable regulations to establish minimum standards for loss ratios of Medicare supplement policies on the basis of incurred claims experience, or incurred health care expenses when coverage is provided by a health maintenance organization on a service rather than reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

HISTORY: Laws, 1981, ch. 433, § 4; Laws, 1992, ch. 337 § 5, eff from and after passage (approved April 20, 1992).

Editor's Notes — Section 8 of Chapter 433, Laws of 1981, provides as follows:
"SECTION 8. This act shall be effective on October 1, 1981, and shall apply to policies and subscriber contracts delivered or issued for delivery in this state after such later date as is specified in the regulations adopted by the commissioner."

RESEARCH REFERENCES

Am. Jur.
70A Am. Jur. 2d, Social Security and Medicare §§ 2045, 2063, 2112, 2439.

CJS.
81 C.J.S. Social Security and Public Welfare §§ 231-246.

§ 83-9-108. Mammography; optional coverage; written acceptance or rejection; application of section.

(1) Every insurer shall offer in each group or individual policy, contract or certificate of health insurance issued or renewed for persons who are residents of this state, coverage for annual screenings by low-dose mammography for all women thirty-five (35) years of age or older for the presence of occult breast cancer within the provisions of the policy, contract or certificate. This coverage shall be offered on an optional basis, and each primary insured must accept or reject such coverage in writing and accept responsibility for premium payment.

(2) Such benefits shall be at least as favorable as for other radiological examinations and subject to the same dollar limits, deductibles and coinsurance factors. For purposes of this section, "low-dose mammography" means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films and cassettes with a radiation exposure which is diagnostically valuable and in keeping with the recommended "Average Patient Exposure Guides" as published by the Conference of Radiation Control Program Directors, Inc.

(3) Except for cancer policies, nothing in this section shall apply to accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care or limited benefit health insurance policies.

HISTORY: Laws, 1998, ch. 483, § 3, eff from and after January 1, 1999.

§ 83-9-109. Outline of coverage.

(1) In order to provide for full and fair disclosure in the sale of Medicare supplement policies, no Medicare supplement policy or certificate shall be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(2) The commissioner shall prescribe the format and content of the outline of coverage required by subsection (1). For purposes of this section, "format" means style, arrangement and overall appearance, including such items as the size, color and prominence of type and the arrangement of text and captions. Such outline of coverage shall include:

(a) A description of the principal benefits and coverage provided in the policy;

(b) A statement of the renewal provisions including any reservation by the insurer of a right to change premiums and disclosure of any automatic renewal premium increases based on the policyholder's age;

(c) A statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(3) The commissioner may prescribe by regulation a standard form and the contents of an informational brochure for persons eligible for Medicare which is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by regulation that the informational brochure be provided to any prospective insureds eligible for Medicare concurrently with delivery of the outline of coverage. With respect to direct response insurance policies, the commissioner may require by regulation that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

(4) The commissioner may adopt regulations for captions or notice requirements, determined to be in the public interest and designed to inform prospective insureds that particular insurance coverages are not Medicare

supplement coverages, for all accident and health insurance policies sold to persons eligible for Medicare other than:

(a) Medicare supplement policies; or

(b) Disability income policies.

(5) The commissioner may adopt reasonable regulations to govern the full and fair disclosure of information in connection with the replacement of accident and health policies, subscriber contracts or certificates by persons eligible for Medicare.

HISTORY: Laws, 1981, ch. 433, § 5; Laws, 1992, ch. 337 § 6; Laws, 1996, ch. 321, § 3, eff from and after passage (approved March 17, 1996).

Editor's Notes — Section 8 of Chapter 433, Laws of 1981, provides as follows:

"SECTION 8. This act shall be effective on October 1, 1981, and shall apply to policies and subscriber contracts delivered or issued for delivery in this state after such later date as is specified in the regulations adopted by the commissioner."

RESEARCH REFERENCES

ALR.

Insurer's duty, and effect of its failure, to provide insured or payee with copy of policy or other adequate documentation of its terms. 78 A.L.R.4th 9.

Am. Jur.

70A Am. Jur. 2d, Social Security and Medicare §§ 2045, 2063, 2112, 2439.

CJS.

81 C.J.S., Social Security and Public Welfare §§ 231-246.

§ 83-9-110. Review and approval of advertising by commissioner.

Every issuer of Medicare supplement insurance policies or certificates in this state shall provide a copy of any Medicare supplement advertisement intended for use in this state whether through written, radio or television medium to the commissioner for review and approval.

HISTORY: Laws, 1992, ch. 337 § 7, eff from and after passage (approved April 20, 1992).

§ 83-9-111. Right to return policy or certificate.

Medicare supplement policies or certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the applicant shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

HISTORY: Laws, 1981, ch. 433, § 6; Laws, 1992, ch. 337 § 8, eff from and after passage (approved April 20, 1992).

Editor's Notes — Section 8 of Chapter 433, Laws of 1981, provides as follows:
"SECTION 8. This act shall be effective on October 1, 1981, and shall apply to policies and subscriber contracts delivered or issued for delivery in this state after such later date as is specified in the regulations adopted by the commissioner."

RESEARCH REFERENCES

ALR.
Insurer's duty, and effect of its failure, to provide insured or payee with copy of policy or other adequate documentation of its terms. 78 A.L.R.4th 9.

Am. Jur.
70A Am. Jur. 2d, Social Security and Medicare §§ 2045, 2063, 2112, 2439.

CJS.
81 C.J.S., Social Security and Public Welfare §§ 231-246.

§ 83-9-112. Penalty for issuers violating statutory provisions.

In addition to any other applicable penalties for violations of the insurance code, the commissioner may require issuers violating any provision of Sections 83-9-101 through 83-9-115 or regulations promulgated pursuant to Sections 83-9-101 through 83-9-115 to cease marketing any Medicare supplement policy or certificate in this state which is related directly or indirectly to a violation or may require such issuer to take such actions as are necessary to comply with the provisions of Sections 83-9-101 through 83-9-115, or both.

HISTORY: Laws, 1992, ch. 337 § 9, eff from and after passage (approved April 20, 1992).

Cross References — General penalty for violation of Mississippi insurance laws, see § 83-5-85.

§ 83-9-113. Regulations subject to administrative procedures law.

Regulations promulgated pursuant to Sections 83-9-101 through 83-9-115 shall be subject to the provisions of Chapter 43 of Title 25, Mississippi Code of 1972.

HISTORY: Laws, 1981, ch. 433, § 7, eff from and after October 1, 1981.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "83-9-115" for "83-9-113" in the middle. The Joint Committee ratified the correction at its August 10, 2022, meeting.

Editor's Notes — Section 8 of Chapter 433, Laws of 1981, provides as follows:
"SECTION 8. This act shall be effective on October 1, 1981, and shall apply to policies and subscriber contracts delivered or issued for delivery in this state after such later date as is specified in the regulations adopted by the commissioner."

Cross References — Administrative procedures, see §§ 25-43-1.101 et seq.

RESEARCH REFERENCES

Am. Jur.
70A Am. Jur. 2d, Social Security and Medicare §§ 2045, 2063, 2112, 2439.

CJS.
81 C.J.S., Social Security and Public Welfare §§ 231-246.

§ 83-9-115. Effect of partial invalidity of provisions.

If any provision of Sections 83-9-101 through 83-9-115 or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of Sections 83-9-101 through 83-9-115 and the application of such provision to other persons or circumstances shall not be affected thereby.

HISTORY: Laws, 1992, ch. 337 § 10, eff from and after passage (approved April 20, 1992).

COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION

Sec.
83-9-201. Short title.
83-9-203. Purpose.
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83-9-209. Eligibility for coverage; maximum lifetime benefits; termination of coverage; unfair trade practice by insurers, agents or brokers, or employers.
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83-9-213. General powers and duties of association; liability of Commissioner of Insurance, administrator, board of directors, etc.; powers and duties of Department of Insurance.
83-9-214. Distribution of funds held by Comprehensive Health Insurance Risk Pool Association upon cessation of operations.
83-9-215. Selection of plan administrator; term, powers and duties, and compensation of administrator.
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83-9-219. Insurance of plan coverage; issuance of policies.
83-9-221. Coverage; rates; exclusion for preexisting conditions; certain individuals excepted from exclusion; other sources primary.
83-9-222. Actions against association or members based upon joint or collective actions.
83-9-223. Repealed.

§ 83-9-201. Short title.

Sections 83-9-201 through 83-9-222 shall be known and may be cited as the “Comprehensive Health Insurance Risk Pool Association Act.”

HISTORY: Laws, 1991, ch. 593, § 1; reenacted, Laws, 1995, ch. 490, § 1; reenacted and amended, Laws, 1997, ch. 311, § 1, eff from and after July 1, 1997.

RESEARCH REFERENCES

Practice References.
Business Law Monographs, Volume IN1—Business Uses of Life Insurance (Matthew Bender Elite Products).

§ 83-9-203. Purpose.

It is the purpose of the Legislature to establish a mechanism to allow the availability of a health insurance program and to allow the availability of health and accident insurance coverage to those citizens of this state who (a) because of health conditions cannot secure such coverage, or (b) desire to obtain or continue health insurance coverage under any state or federal program designed to enable persons to obtain or maintain health insurance coverage.

HISTORY: Laws, 1991, ch. 593, § 2; reenacted, Laws, 1995, ch. 490, § 2; reenacted without change, Laws, 1997, ch. 311, § 2; Laws, 2009, ch. 385, § 1, eff from and after July 1, 2009.

§ 83-9-205. Definitions.

As used in Sections 83-9-201 through 83-9-222, the following words shall have the meaning ascribed herein unless the context clearly requires otherwise:

(a) "Association" means the Comprehensive Health Insurance Risk Pool Association.

(b) "Board" means the board of directors of the association.

(c) "Church plan" has the meaning given such term under Section 3(33) of the Employee Retirement Income Security Act of 1974.

(d) "Commissioner" means the Commissioner of Insurance of this state.

(e) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 USCS Section 9801(c)(1)). A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under the plan, if, after such period and before the enrollment date, the individual experiences a significant break in coverage.

(f) "Dependent" means a resident spouse or resident unmarried child under the age of nineteen (19) years, a child who is a student under the age of twenty-three (23) years and who is financially dependent upon the parent or a child of any age who is disabled and dependent upon the parent.

(g) "Excess or stoploss coverage" means an arrangement whereby an insurer insures against the risk that any one (1) claim will exceed a specific dollar amount or that the entire loss of a self-insurance plan will exceed a specific amount.

(h) "Federally defined eligible individual" means an individual:

(i) For whom, as of the date on which the individual seeks coverage under the plan, the aggregate of the periods of creditable coverage is eighteen (18) or more months;

(ii) Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with such a plan;

(iii) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (Medicare), or a state plan under Title XIX of the act (Medicaid) or any successor program, and who does not have other health insurance coverage;

(iv) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(v) Who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected this coverage; and

(vi) Who has exhausted continuation coverage under this provision or program, if the individual elected the continuation coverage described in subparagraph (v).

(i) "Governmental plan" has the meaning given such term under Section 3(32) of the Employee Retirement Income Security Act of 1974 and any federal governmental plan.

(j) "Group health plan" means an employee welfare benefit plan as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise.

(k) "Health insurance coverage" means any hospital and medical expense incurred policy, nonprofit health care services plan contract, health maintenance organization subscriber contract or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.

(i) "Health insurance coverage" shall not include one or more, or any combination of, the following:

1. Coverage only for accident, or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Workers' compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; and

8. Other similar insurance coverage, specified in federal regulations issued pursuant to Public Law 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(ii) "Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:

1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

3. Other similar, limited benefits specified in federal regulations issued pursuant to Public Law 104-191.

(iii) "Health insurance coverage" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

1. Coverage only for a specified disease or illness; or

2. Hospital indemnity or other fixed indemnity insurance.

(iv) "Health insurance coverage" shall not include the following if offered as a separate policy, certificate or contract of insurance:

1. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

2. Coverage supplemental to the coverage provided under Chapter 55, Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or

3. Similar supplemental coverage provided to coverage under a group health plan.

(*l*) "Health maintenance organization" means any organization authorized under the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plans Protection Act, Section 83-41-301 et seq., to operate a health maintenance organization in this state.

(m) "Insurer" means any entity that is authorized in this state to write health insurance coverage or that provides health insurance coverage in this state or any third-party administrator. For the purposes of Sections 83-9-201 through 83-9-222, insurer includes an insurance company, nonprofit health care services plan, fraternal benefit society, health maintenance organization, to the extent consistent with federal law any self-insurance arrangement covered by the Employee Retirement Income Security Act of 1974, as amended, that provides health care benefits in this state, any other entity providing a plan of health insurance coverage or health benefits subject to state insurance regulation and any reinsurer reinsuring health insurance coverage in this state.

(n) "Medicare" means coverage under both Parts A or B of Title XVIII of the Social Security Act, 42 USC, Section 1395 et seq., as amended.

(o) "Plan" means the health insurance plan adopted by the board under Sections 83-9-201 through 83-9-222.

(p) "Resident" means an individual who is legally located in the United States and has been legally domiciled in this state for a period to be established by the board and subject to the approval of the commissioner but in no event shall such residency requirement be greater than one (1) year, except that for a federally defined eligible individual, there shall not be a prior residency requirement.

(q) "Agent" means a person who is licensed to sell health insurance in this state or a third-party administrator.

(r) "Covered person" means any individual resident of this state (excluding dependents) who is eligible to receive benefits from any insurer.

(s) "Third-party administrator" means any entity who is paying or processing health insurance claims for any Mississippi resident.

(t) "Reinsurer" means any insurer from whom any person providing health insurance coverage for any Mississippi resident procures insurance for itself in the insurer, with respect to all or part of the health insurance coverage risk of the person.

(u) "Significant break in coverage" means a period of sixty-three (63) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

HISTORY: Laws, 1991, ch. 593, § 3; Laws, 1995, ch. 490, § 3; reenacted and amended, Laws, 1997, ch. 311, § 3; Laws, 2009, ch. 385, § 2, eff from and after July 1, 2009.

Cross References — Medicare supplement insurance, see §§ 83-9-101 et seq.

Federal Aspects — Chapter 55 of Title 10 of the U.S. Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)) is codified as 10 USCS §§ 1071 et seq. Employee Retirement Income Security Act generally, see 29 USCS §§ 1001 et seq. Sections 3(1), (32) and (33) of the Employee Retirement Income Security Act are codified as 29 USCS § 1002(1), (32) and (33), respectively. Parts A and B of Title XVIII of the Social Security Act are codified as 42 USCS §§ 1395c through 1395w-4. Section 1882(g)(1) of the Social Security Act is codified as 42 USCS § 1395ss(g)(1). Title XIX of the Social Security Act is codified as 42 USCS §§ 1396 et seq.

RESEARCH REFERENCES

Practice References.
Business Law Monographs, Volume IN2 —Casualty and Liability Insurance (Matthew Bender).

§ 83-9-207. Participation by insurers; availability of policies for sale.

(1) Every insurer shall participate in the association.

(2) The requirements of this plan shall become effective April 15, 1991. The policies shall be available for sale January 1, 1992.

HISTORY: Laws, 1991, ch. 593, § 4; reenacted, Laws, 1995, ch. 490, § 4; reenacted without change, Laws, 1997, ch. 311, § 4, eff from and after July 1, 1997.

§ 83-9-209. Eligibility for coverage; maximum lifetime benefits; termination of coverage; unfair trade practice by insurers, agents or brokers, or employers.

(1) Any individual who is and continues to be a resident shall be eligible for coverage under this plan if evidence is provided of:

(a) A notice of rejection or refusal to issue health insurance coverage for health reasons by one (1) insurer;

(b) A refusal by an insurer to issue health insurance coverage except with material underwriting restriction; or

(c) A refusal by an insurer to issue health insurance coverage except at a rate exceeding the plan rate.

(2) The board shall develop a procedure for eligibility for coverage by the association for any natural person who changes his domicile to this state and who at the time domicile is established in this state is insured by an organization similar to the association. The eligible maximum lifetime benefits for such covered person shall not exceed the lifetime benefits available through the association, less any benefits received from a similar organization in the former domiciliary state.

(3) The board may promulgate a list of medical or health conditions for which a person shall be eligible for plan coverage without applying for health insurance coverage under subsection (1) of this section. Persons who can demonstrate the existence or history of any medical or health conditions on such list promulgated by the board may not be required to provide the evidence specified in subsection (1) of this section. Any such list previously promulgated by the board may be amended or repealed by the board from time to time as may be appropriate.

(4) A person shall not be eligible for coverage under this plan if:

(a) The person has or obtains health insurance coverage, or would be eligible to have coverage if the person elected to obtain it; except that:

(i) A person may maintain other coverage for the period of time the person is satisfying a preexisting condition waiting period under a plan policy; and

(ii) A person may maintain plan coverage for the period of time the person is satisfying a preexisting condition waiting period under another health insurance policy intended to replace the plan policy.

(b) The person is determined to be eligible for health care benefits under the Mississippi Medicaid Law, Section 43-13-101 et seq., or Medicare.

(c) The person previously terminated plan coverage unless twelve (12) months have elapsed since the person's latest termination.

(d) The plan has paid out One Million Dollars ($1,000,000.00) in benefits on behalf of the person. The lifetime maximum shall be One Million Dollars ($1,000,000.00).

(e) The person is an inmate or resident of a public institution.

(f) The person's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.

(5) The coverage of any person shall cease:

(a) On the date a person is no longer a resident of this state;

(b) Upon the death of the covered person;

(c) On the date state law requires cancellation of the policy; or

(d) At the option of the association, thirty (30) days after the association makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.

(6) The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated immediately.

(7) It shall constitute an unfair trade practice for any insurer, insurance agent or broker, employer or third-party administrator to refer an individual employee or a dependent of an individual employee to the association, or to arrange for an individual employee or a dependent of an individual employee to apply to the program, for the purpose of separating such employee or dependent from a group health benefits plan provided in connection with the employee's employment.

HISTORY: Laws, 1991, ch. 593, § 5; Laws, 1995, ch. 490, § 5; reenacted and amended, Laws, 1997, ch. 311, § 5; Laws, 2009, ch. 385, § 3; Laws, 2016, ch. 306, § 1, eff from and after passage (approved Apr. 4, 2016).

Federal Aspects — Medicare, Title XVIII of the Social Security Act, is codified as 42 USCS §§ 1395 et seq.

§ 83-9-211. Creation of association; membership; board of directors; adoption of plan, articles, bylaws and operating rules.

(1) There is created a nonprofit legal entity to be known as the "Comprehensive Health Insurance Risk Pool Association." All insurers, as a condition of doing business, shall be members of the association.

(2)(a) The association shall operate subject to the supervision and approval of an eleven-member board of directors consisting of:

(i) Six (6) members appointed by the Insurance Commissioner. Two (2) of the commissioner's appointees shall be chosen from the general public and shall not be associated with the medical profession, a hospital or an insurer. Two (2) appointees shall be representatives of medical providers. One (1) appointee shall be a representative of businesses employing fewer than one hundred (100) employees. One (1) appointee shall be a representative of health insurance agents. Any board member appointed by the commissioner may be removed and replaced by him at any time without cause.

(ii) Three (3) members appointed by the participating insurers, at least one (1) of whom is a domestic insurer.

(iii) The Chair of the Senate Insurance Committee and the Chair of the House Insurance Committee, or their designees, who shall be nonvoting, ex officio members of the board.

(iv) Of those initial members appointed by the Insurance Commissioner, one (1) shall serve for a term of one (1) year, two (2) for a term of two (2) years, and one (1) for a term of three (3) years. Of those initial members appointed by the participating insurers, one (1) shall serve for a term of one (1) year, one (1) shall serve for a term of two (2) years, and one (1) shall serve for a term of three (3) years. The appointing authority shall designate the period of service of each initial appointee at the time of appointment.

(v) All appointments after the initial term shall be for a term of three (3) years.

(b) The board of directors shall elect one (1) of its members as chairman.

(c) Board members may be reimbursed from monies of the association for actual and necessary expenses incurred by them as members in the manner and amount provided in Section 25-3-41, Mississippi Code of 1972, but shall not otherwise be compensated for their services.

(3) The association shall adopt a plan in accordance with Sections 83-9-201 through 83-9-222 and submit its articles, bylaws and operating rules to the State Department of Insurance for approval. If the association fails to adopt such plan and suitable articles, bylaws and operating rules within ninety (90) days after the appointment of the board, the State Department of Insurance shall adopt rules to effectuate the provisions of Sections 83-9-201 through 83-9-222; and such rules shall remain in effect until superseded by a plan and articles, bylaws and operating rules submitted by the association and approved by the State Department of Insurance.

(4) Individual board members shall not be liable and shall be immune from suit at law or equity for any conduct performed in good faith and which is within the subject matter over which they have been given jurisdiction.

HISTORY: Laws, 1991, ch. 593, § 6; Laws, 1995, ch. 490, § 6; reenacted and amended, Laws, 1997, ch. 311, § 6; Laws, 2009, ch. 385, § 4; Laws, 2012, ch. 302, § 1, eff from and after passage (approved Mar. 30, 2012).

§ 83-9-212. Liability of board, employees, insurers, association, etc. for obligations of association or acts or omissions; indemnification and representation of board and employees.

Neither the board nor its employees shall be liable for any obligations of the association. There shall be no liability on the part of and no cause of action shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors or the commissioner or his representatives for any action or omission by them in the performance of their powers and duties under Sections 83-9-201 through 83-9-222. The board may provide in its bylaws or rules for indemnification of, and legal representation for, its members and employees.

HISTORY: Laws, 1995, ch. 490, § 7; reenacted and amended, Laws, 1997, ch. 311, § 7, eff from and after July 1, 1997.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
40 Am. Jur. 2d, Hospitals and Asylums §§ 6-13, 14-45.	41 C.J.S., Hospitals §§ 11-14, 18-32, 33-43.

§ 83-9-213. General powers and duties of association; liability of Commissioner of Insurance, administrator, board of directors, etc.; powers and duties of Department of Insurance.

(1) The association shall:

(a) Establish administrative and accounting procedures for the operation of the association.

(b) Establish procedures under which applicants and participants in the plan may have grievances reviewed by an impartial body and reported to the board.

(c) Select an administering insurer in accordance with Section 83-9-215.

(d) Collect the assessments provided in Section 83-9-217 from insurers and third-party administrators for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board. Assessments shall be collected pursuant to the plan of operation approved by the board. In addition to the collection of such assessments, the association shall collect an organizational assessment or assessments from all insurers as necessary to provide for expenses which have been incurred or are estimated to be incurred prior to receipt of the first calendar year assessments. Organizational assessments shall be equal in amount for all insurers, but shall not exceed One Hundred Dollars ($100.00) per insurer for all such assessments. Assessments are due and payable within thirty (30) days of receipt of the assessment notice by the insurer.

(e) Require that all policy forms issued by the association conform to standard forms developed by the association. The forms shall be approved by the State Department of Insurance.

(f) Develop and implement a program to publicize the existence of the plan, the eligibility requirements for the plan, and the procedures for enrollment in the plan and to maintain public awareness of the plan.

(2) The association may:

(a) Exercise powers granted to insurers under the laws of this state.

(b) Take any legal actions necessary or proper for the recovery of any monies due the association under Sections 83-9-201 through 83-9-222. There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner of Insurance or any of his staff, the administrator, the board or its directors, agents or employees, or against any participating insurer for any actions performed in accordance with Sections 83-9-201 through 83-9-222.

(c) Enter into contracts as are necessary or proper to carry out the provisions and purposes of Sections 83-9-201 through 83-9-222, including the authority, with the approval of the commissioner, to enter into contracts with similar organizations of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.

(d) Sue or be sued, including taking any legal actions necessary or proper to recover or collect assessments due the association.

(e) Take any legal actions necessary to:

(i) Avoid the payment of improper claims against the association or the coverage provided by or through the association.

(ii) Recover any amounts erroneously or improperly paid by the association.

(iii) Recover any amounts paid by the association as a result of mistake of fact or law.

(iv) Recover other amounts due the association.

(f) Establish, and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the association. Rates and rate schedules may be adjusted for appropriate factors such as age, sex and geographic variation in claim cost and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices.

(g) Issue policies of insurance in accordance with the requirements of Sections 83-9-201 through 83-9-222.

(h) Appoint appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the plan, policy and other contract design, and any other function within the authority of the association.

(i) Borrow money to effect the purposes of the association. Any notes or other evidence of indebtedness of the association not in default shall be legal investments for insurers and may be carried as admitted assets.

(j) Establish rules, conditions and procedures for reinsuring risks of member insurers desiring to issue plan coverages to individuals otherwise eligible for plan coverages in their own name. Provision of reinsurance shall not subject the association to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

(k) Prepare and distribute application forms and enrollment instruction forms to insurance producers and to the general public.

(*l*) Provide for reinsurance of risks incurred by the association.

(m) Issue additional types of health insurance policies to provide optional coverages, including Medicare supplemental health insurance.

(n) Provide for and employ cost containment measures and requirements including, but not limited to, disease management programs and incentives for participation therein, preadmission screening, second surgical opinion, concurrent utilization review and individual case management for the purpose of making the benefit plan more cost effective.

(o) Design, utilize, contract or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations and other limited network provider arrangements.

(p) Serve as a mechanism to provide health and accident insurance coverage to citizens of this state under any state or federal program designed to enable persons to obtain or maintain health insurance coverage.

(3) The commissioner may, by rule, establish additional powers and duties of the board and may adopt such rules as are necessary and proper to implement Sections 83-9-201 through 83-9-222.

(4) The State Department of Insurance shall examine and investigate the association and make an annual report to the Legislature thereon. Upon such investigation, the Commissioner of Insurance, if he deems necessary, shall require the board: (a) to contract with an outside independent actuarial firm to assess the solvency of the association and for consultation as to the sufficiency and means of the funding of the association, and the enrollment in and the eligibility, benefits and rate structure of the benefits plan to ensure the solvency of the association; and (b) to close enrollment in the benefits plan at any time upon a determination by the outside independent actuarial firm that funds of the association are insufficient to support the enrollment of additional persons. In no case shall the commissioner require such actuarial study any less than once every two (2) years.

HISTORY: Laws, 1991, ch. 593, § 7; Laws, 1995, ch. 490, § 8; reenacted and amended, Laws, 1997, ch. 311, § 8; Laws, 2009, ch. 385, § 5, eff from and after July 1, 2009.

§ 83-9-214. Distribution of funds held by Comprehensive Health Insurance Risk Pool Association upon cessation of operations.

Upon the cessation of operations by the Comprehensive Health Insurance Risk Pool Association, the distribution of any funds held by the association, including the refund of assessments, shall require the prior approval of the Commissioner of Insurance.

HISTORY: Laws, 2018, ch. 384, § 1, eff from and after passage (approved March 19, 2018).

§ 83-9-215. Selection of plan administrator; term, powers and duties, and compensation of administrator.

(1) The board shall select an insurer, through a competitive bidding process, to administer the plan. The board shall evaluate bids submitted under this subsection based on criteria established by the board, which criteria shall include:

(a) The insurer's proven ability to handle large group accident and health insurance.

(b) The efficiency of the insurer's claims-paying procedures.

(c) An estimate of total charges for administering the plan.

(2) The administering insurer shall serve for a period of three (3) years. At least one (1) year prior to the expiration of each three-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer, to submit bids to serve as the administering insurer for the succeeding three-year period. The selection of the administering insurer for the succeeding period shall be made at least six (6) months prior to the end of the current three-year period.

(3) The administering insurer shall:

(a) Perform all eligibility and administrative claims-payment functions relating to the plan.

(b) Pay an agent's referral fee as established by the board to each insurance agent who refers an applicant to the plan, if the applicant's application is accepted. The selling or marketing of plans shall not be limited to the administering insurer or its agents. The referral fees shall be paid by the administering insurer from monies received as premiums for the plan.

(c) Establish a premium-billing procedure for collection of premiums from insured persons. Billings shall be made periodically as determined by the board.

(d) Perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including:

(i) Making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made.

(ii) Evaluating the eligibility of each claim for payment under the plan.

(iii) Notifying each claimant within forty-five (45) days after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected or compromised.

(iv) The board shall establish reasonable reimbursement amounts for any services covered under the benefit plans.

(e) Submit regular reports to the board regarding the operation of the plan. The frequency, content and form of the reports shall be as determined by the board.

(f) Following the close of each calendar year, determine net premiums, reinsurance premiums less administrative expense allowance, the expense of administration pertaining to the reinsurance operations of the association, and the incurred losses of the year and report this information to the association and the State Department of Insurance.

(g) Pay claims expenses. If the payments by the administering insurer for claims expenses exceed the portion of premiums allocated by the board for payment of claims expenses, the board shall provide the administering insurer with additional funds for payment of claims expenses.

(4)(a) The administering insurer shall be paid, as provided in the contract of the association, for its direct and indirect expenses incurred in the performance of its services.

(b) As used in this subsection, the term "direct and indirect expenses" includes that portion of the audited administrative costs, printing expenses, claims administration expenses, management expenses, building overhead expenses and other actual operating and administrative expenses of the administering insurer which are approved by the board as allocable to the administration of the plan and included in the bid specifications.

HISTORY: Laws, 1991, ch. 593, § 8; Laws, 1995, ch. 490, § 9; reenacted without change, Laws, 1997, ch. 311, § 9; Laws, 2009, ch. 385, § 6, eff from and after July 1, 2009.

Cross References — General powers and duties of association, see § 83-9-213.

§ 83-9-217. Assessments against insurers.

(1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(2) Each insurer shall be assessed an amount not to exceed Three Dollars ($3.00) per covered person insured or reinsured by each insurer per month. There shall not be such assessment on any insurer on policies or contracts insuring federal or state employees.

(3) The board shall make reasonable efforts designed to ensure that each covered person is counted only once with respect to any assessment. For that purpose, the board shall require each insurer that obtains excess or stoploss insurance to include in its count of covered persons all individuals whose coverage is insured (including by way of excess or stoploss coverage) in whole or part. The board shall allow a reinsurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stoploss insurer for the purpose of determining its assessment under this subsection.

(4) Each insurer's assessment may be verified by the board based on annual statements and other reports deemed to be necessary by the board. The board may use any reasonable method of estimating the number of covered persons of an insurer if the specific number is unknown.

(5) If assessments and other receipts by the association, board or administering insurer exceed the actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses or to reduce plan premiums.

As used in this subsection, the term "future losses" includes reserves for claims incurred but not reported.

(6) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment or otherwise file any report or furnish information required to be filed with the board pursuant to the board's direction that the board determines is necessary in order for the board to perform its duties under this section. As an alternative, the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than One Hundred Dollars ($100.00) per month.

HISTORY: Laws, 1991, ch. 593, § 9; Laws, 1995, ch. 490, § 10; reenacted without change, Laws, 1997, ch. 311, § 10; Laws, 2002, ch. 564, § 1; Laws, 2009, ch. 385, § 7, eff from and after July 1, 2009.

Cross References — General powers and duties of association, see § 83-9-213.

OPINIONS OF THE ATTORNEY GENERAL

Insurers of municipal employees are not exempt from the one dollar assessment per covered person per month imposed by statute. Ellis, May 8, 1992, A.G. Op. #92-0342.

RESEARCH REFERENCES

ALR.

Requirement that multicoverage umbrella insurance policy offer uninsured-or underinsured-motorist coverage equal to liability limits under umbrella provisions. 52 A.L.R.5th 451.

§ 83-9-219. Insurance of plan coverage; issuance of policies.

The coverage provided by the plan shall be directly insured by the association, and the policies shall be issued through the administering insurer. Subject to the approval of the commissioner, the association may close enrollment in, and/or cease to offer the coverage provided by, the plan at any time upon a determination by the board that the availability of such coverage is no longer necessary.

HISTORY: Laws, 1991, ch. 593, § 10; reenacted, Laws, 1995, ch. 490, § 11; reenacted without change, Laws, 1997, ch. 311, § 11; Laws, 2016, ch. 306, § 2, eff from and after passage (approved Apr. 4, 2016).

§ 83-9-221. Coverage; rates; exclusion for preexisting conditions; certain individuals excepted from exclusion; other sources primary.

(1) **Coverage offered.**

(a) The plan shall offer the coverage specified in this section for each eligible person subject to the association's discretion to close enrollment and/or cease offering coverage as authorized in Section 83-9-219.

(b) If an eligible person is also eligible for Medicare coverage, the plan shall not pay or reimburse any person for expenses paid by Medicare.

(c) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium may apply for coverage under the plan. If such coverage is applied for within sixty-three (63) days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of termination of the previous coverage.

(2) **Major medical expense coverage.** The coverage issued by the plan, its schedule of benefits, exclusions and other limitations shall be established by the board and may be amended from time to time subject to the approval of the commissioner.

(3) In establishing the plan coverage, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate; and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance coverage provided through a representative number of large employers in the state.

(4) Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage.

(a) Separate schedules of premium rates based on age may apply for individual risks.

(b) Rates are subject to approval by the State Department of Insurance.

(c) Standard risk rates for coverages issued by the association shall be established by the association, subject to approval by the department, using reasonable actuarial techniques, and shall reflect anticipated experiences and expenses of such coverages for standard risks.

(d) The rating plan established by the association shall initially provide for rates equal to one hundred fifty percent (150%) of the average standard risk rates. Any changes in the initial rates shall be based on experience of the plan and shall reflect reasonably anticipated losses and expenses.

(e) No rate shall exceed one hundred seventy-five percent (175%) of the standard risk rate.

(5) **Preexisting conditions.** An association policy may contain provisions under which coverage is excluded during a period of twelve (12) months following the effective date of coverage with respect to a given covered individual for any preexisting condition, as long as:

(a) The condition manifested itself within a period of six (6) months before the effective date of coverage;

(b) Medical advice or treatment was recommended or received within a period of six (6) months before the effective date of coverage.

(6) **Other sources primary.**

(a) The association shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. The coverage provided by the association shall be considered excess coverage, and benefits otherwise payable under association coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable by any insurer or insurance arrangement or any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(b) No amounts paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may be made or recognized as claims under such policy or be recognized as or towards satisfaction of applicable deductibles or out-of-pocket maximums or to reduce the limits of benefits available.

(c) The association shall have a cause of action against a participant for the recovery of the amount of any benefits paid to the participant which should not have been claimed or recognized as claims because of the provisions of this subsection or because otherwise not covered. Benefits due from the association may be reduced or refused as a setoff against any amount recoverable under this paragraph.

HISTORY: Laws, 1991, ch. 593, § 11; Laws, 1995, ch. 490, § 12; reenacted and amended, Laws, 1997, ch. 311, § 12; Laws, 2009, ch. 385, § 8; Laws, 2016, ch. 306, § 3, eff from and after passage (approved Apr. 4, 2016).

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted the designations (5)(a) and (5)(b) for (5)(i) and (5)(ii). The Joint Committee ratified the correction at its August 10, 2022, meeting.

RESEARCH REFERENCES

ALR.

Construction and application of provision in health or hospitalization policy excluding or postponing coverage of illness originating prior to issuance of policy or within stated time. 94 A.L.R.3d 990.

Applicability of other insurance benefits exclusion from coverage of hospital or health and accident policy to governmental insurance benefits to which insured would have been entitled by prior subscription. 29 A.L.R.4th 361.

§ 83-9-222. Actions against association or members based upon joint or collective actions.

Neither the participation in the association as member insurers, the establishment of rates, forms or procedures nor any other joint or collective action required by Sections 83-9-201 through 83-9-222 shall be the basis of any legal action, criminal or civil liability or penalty against the association or any member insurer.

HISTORY: Laws, 1995, ch. 490, § 14; reenacted and amended, Laws, 1997, ch. 311, § 13, eff from and after July 1, 1997.

§ 83-9-223. Repealed.

Repealed by Laws of 1997, ch. 311, § 14, eff from and after July 1, 1997. § 83-9-223. [Laws, 1991, ch. 593, § 12; Laws, 1995, ch. 490, § 13]

Editor's Notes — Former § 83-9-223 provided for the repeal of the Comprehensive Health Insurance Risk Pool Association Act, §§ 83-9-201 through 83-9-223.

BASIC GROUP HEALTH INSURANCE FOR SMALL BUSINESS

Sec.
83-9-301. Repealed.
83-9-303. Basic group health insurance policy offered to employers of small numbers of employees.

§ 83-9-301. Repealed.

Repealed by Laws of 1994, ch. 329, § 2, eff from and after July 1, 1994. § 83-9-301. [Laws, 1992, ch. 541, § 1]

Editor's Notes — Former § 83-9-301 was entitled: Legislative findings and intent. Laws of 1992, ch. 541, § 3, provided for the repeal of this section effective July 1, 1994. Subsequently Laws of 1994, ch. 329, § 3, repealed Laws of 1992, ch. 541, § 3.

RESEARCH REFERENCES

Practice References.
Business Law Monographs, Volume IN1—Business Uses of Life Insurance (Matthew Bender Elite Products).

§ 83-9-303. Basic group health insurance policy offered to employers of small numbers of employees.

(1) A basic group health insurance policy shall be offered to employers of fewer than twenty-five (25) employees. Such a basic group health policy shall provide coverage for hospital expenses and services rendered by a physician licensed by this state, but is not subject to the requirements of state mandated benefit for health insurance.

(2) Nothing in this section shall prohibit an insurer from offering, or a purchaser from seeking, benefits in excess of the basic coverage authorized herein. Nothing in this section shall restrict the right of employees to collectively bargain for insurance providing benefits in excess of those provided herein.

(3) All forms, policies and contracts shall be submitted for approval to the Commissioner of Insurance, and the rates of any plan offered under this section shall be reasonable in relation to the benefits thereto.

HISTORY: Laws, 1992, ch. 541, § 2; reenacted, Laws, 1994, ch. 329, § 1, eff from and after July 1, 1994.

Editor's Notes — Laws of 1992, ch. 541, § 3, provided for the repeal of this section effective July 1, 1994. Subsequently Laws of 1994, ch. 329, § 3, repealed Laws of 1992, ch. 541, § 3.

COVERAGE FOR TELEMEDICINE SERVICES

Sec.	
83-9-351.	Health insurance plans in Mississippi to provide coverage for telemedicine services; definitions [Repealed effective July 1, 2025].
83-9-353.	Coverage and reimbursement for store-and-forward telemedicine services and remote patient monitoring services; definitions.

§ 83-9-351. Health insurance plans in Mississippi to provide coverage for telemedicine services; definitions [Repealed effective July 1, 2025].

(1) As used in this section:

(a) "Employee benefit plan" means any plan, fund or program established or maintained by an employer or by an employee organization, or both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, hospital care or other benefits.

(b) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, and includes the State and School Employees Health Insurance Plan and any other public health care assistance program offered or administered by the state or any political subdivision or instrumentality of the state. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

(c) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, health maintenance organization, preferred provider organization, managed care organization, pharmacy benefit manager, and, to the extent permitted under federal law, any administrator of an insured, self-insured or publicly funded health care benefit plan offered by public and private entities, and other parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(d) "Telemedicine" means the delivery of health care services such as diagnosis, consultation, or treatment through the use of HIPAA-compliant telecommunication systems, including information, electronic and communication technologies, remote patient monitoring services and store-and-forward telemedicine services. Telemedicine, other than remote patient monitoring services and store-and-forward telemedicine services, must be "real-time" audio visual capable. The Commissioner of Insurance may adopt rules and regulations addressing when "real-time" audio interactions without visual are allowable, which must be medically appropriate for the corresponding health care services being delivered.

(2) All health insurance and employee benefit plans in this state must provide coverage for telemedicine services to the same extent that the services would be covered if they were provided through in-person consultation. All health insurance and employee benefit plans in this state must reimburse providers who are out-of-network for telemedicine services under the same reimbursement policies applicable to other out-of-network providers of health-care services.

(3) A health insurance or employee benefit plan may charge a deductible, co-payment, or coinsurance for a health care service provided through telemedicine so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(4) Nothing in this section shall be construed to prohibit a health insurance or employee benefit plan from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person's policy.

(5) In a claim for the services provided, the appropriate procedure code for the covered services shall be included with the appropriate modifier indicating interactive communication was used. Health insurance and employee benefit plans shall reimburse providers for telemedicine services using the proper medical codes.

(6) The originating site is eligible to receive a facility fee, but facility fees are not payable to the distant site. Health insurance and employee benefit plans shall not limit coverage to provider-to-provider consultations only. Patients in a patient-to-provider consultation shall not be entitled to receive a facility fee.

(7) Nothing in this section shall be interpreted to create new standards of care for health care services delivered through the use of telemedicine.

(8) The Commissioner of Insurance may adopt rules and regulations for the administration of this chapter.

(9) This section shall stand repealed from and after July 1, 2025.

HISTORY: Laws, 2013, ch. 478, § 1; Laws, 2014, ch. 436, § 2, eff from and after July 1, 2014; Laws, 2022, ch. 438, § 1, eff from and after July 1, 2022.

Amendment Notes — The 2022 amendment rewrote (1)(d), which read: "'Telemedicine' means the delivery of health care services such as diagnosis, consultation, or treatment through the use of interactive audio, video, or other electronic media. Telemedicine must be 'real-time' consultation, and it does not include the use of audio-only telephone, e-mail, or facsimile"; in (2), added the last sentence; deleted former (4), which read: "A health insurance or employee benefit plan may limit coverage to health care providers in a telemedicine network approved by the plan"; redesignated former (5) as (4); redesignated former (6) as (5), and therein added the last sentence; redesignated former (7) as (6), and therein added the last two sentences; and added (7) through (9).

§ 83-9-353. Coverage and reimbursement for store-and-forward telemedicine services and remote patient monitoring services; definitions.

(1) As used in this section:

(a) "Employee benefit plan" means any plan, fund or program established or maintained by an employer or by an employee organization, or both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, hospital care or other benefits.

(b) "Health insurance plan" means any health insurance policy or health benefit plan offered by a health insurer, and includes the State and School Employees Health Insurance Plan and any other public health care assistance program offered or administered by the state or any political subdivision or instrumentality of the state. The term does not include policies or plans providing coverage for specified disease or other limited benefit coverage.

(c) "Health insurer" means any health insurance company, nonprofit hospital and medical service corporation, health maintenance organization, preferred provider organization, managed care organization, pharmacy benefit manager, and, to the extent permitted under federal law, any administrator of an insured, self-insured or publicly funded health care benefit plan offered by public and private entities, and other parties that are by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

(d) "Store-and-forward telemedicine services" means the use of asynchronous computer-based communication between a patient and a consulting provider or a referring health care provider and a medical specialist at a distant site for the purpose of diagnostic and therapeutic assistance in the care of patients who otherwise have no access to specialty care. Store-and-forward telemedicine services involve the transferring of medical data from one (1) site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation.

(e) "Remote patient monitoring services" means the delivery of home health services using telecommunications technology to enhance the delivery of home health care, including:

(i) Monitoring of clinical patient data such as weight, blood pressure, pulse, pulse oximetry and other condition-specific data, such as blood glucose;

(ii) Medication adherence monitoring; and

(iii) Interactive video conferencing with or without digital image upload as needed.

(f) "Mediation adherence management services" means the monitoring of a patient's conformance with the clinician's medication plan with respect to timing, dosing and frequency of medication-taking through electronic transmission of data in a home telemonitoring program.

(2) Store-and-forward telemedicine services allow a health care provider trained and licensed in his or her given specialty to review forwarded images and patient history in order to provide diagnostic and therapeutic assistance in the care of the patient without the patient being present in real time. Treatment recommendations made via electronic means shall be held to the same standards of appropriate practice as those in traditional provider-patient setting.

(3) Any patient receiving medical care by store-and-forward telemedicine services shall be notified of the right to receive interactive communication with the distant specialist health care provider and shall receive an interactive communication with the distant specialist upon request. If requested, communication with the distant specialist may occur at the time of the consultation or within thirty (30) days of the patient's notification of the request of the consultation. Telemedicine networks unable to offer the interactive consultation shall not be reimbursed for store-and-forward telemedicine services.

(4) Remote patient monitoring services aim to allow more people to remain at home or in other residential settings and to improve the quality and cost of their care, including prevention of more costly care. Remote patient monitoring services via telehealth aim to coordinate primary, acute, behavioral and long-term social service needs for high-need, high-cost patients. Specific patient criteria must be met in order for reimbursement to occur.

(5) Qualifying patients for remote patient monitoring services must meet all the following criteria:

(a) Be diagnosed, in the last eighteen (18) months, with one or more chronic conditions, as defined by the Centers for Medicare and Medicaid Services (CMS), which include, but are not limited to, sickle cell, mental health, asthma, diabetes, and heart disease; and

(b) The patient's health care provider recommends disease management services via remote patient monitoring.

(6) A remote patient monitoring prior authorization request form may be required for approval of telemonitoring services. If prior authorization is required, the request form must include the following:

(a) An order for home telemonitoring services, signed and dated by the prescribing physician;

(b) A plan of care, signed and dated by the prescribing physician, that includes telemonitoring transmission frequency and duration of monitoring requested;

(c) The client's diagnosis and risk factors that qualify the client for home telemonitoring services;

(d) Attestation that the client is sufficiently cognitively intact and able to operate the equipment or has a willing and able person to assist in completing electronic transmission of data; and

(e) Attestation that the client is not receiving duplicative services via disease management services.

(7) The entity that will provide the remote monitoring must be a Mississippi-based entity and have protocols in place to address all of the following:

(a) Authentication and authorization of users;

(b) A mechanism for monitoring, tracking and responding to changes in a client's clinical condition;

(c) A standard of acceptable and unacceptable parameters for client's clinical parameters, which can be adjusted based on the client's condition;

(d) How monitoring staff will respond to abnormal parameters for client's vital signs, symptoms and/or lab results;

(e) The monitoring, tracking and responding to changes in client's clinical condition;

(f) The process for notifying the prescribing physician for significant changes in the client's clinical signs and symptoms;

(g) The prevention of unauthorized access to the system or information;

(h) System security, including the integrity of information that is collected, program integrity and system integrity;

(i) Information storage, maintenance and transmission;

(j) Synchronization and verification of patient profile data; and

(k) Notification of the client's discharge from remote patient monitoring services or the de-installation of the remote patient monitoring unit.

(8) The telemonitoring equipment must:

(a) Be capable of monitoring any data parameters in the plan of care; and

(b) Be a FDA Class II hospital-grade medical device.

(9) Monitoring of the client's data shall not be duplicated by another provider.

(10) To receive payment for the delivery of remote patient monitoring services via telehealth, the service must involve:

(a) An assessment, problem identification, and evaluation that includes:

(i) Assessment and monitoring of clinical data including, but not limited to, appropriate vital signs, pain levels and other biometric measures specified in the plan of care, and also includes assessment of response to previous changes in the plan of care; and

(ii) Detection of condition changes based on the telemedicine encounter that may indicate the need for a change in the plan of care.

(b) Implementation of a management plan through one or more of the following:

(i) Teaching regarding medication management as appropriate based on the telemedicine findings for that encounter;

(ii) Teaching regarding other interventions as appropriate to both the patient and the caregiver;

(iii) Management and evaluation of the plan of care including changes in visit frequency or addition of other skilled services;

(iv) Coordination of care with the ordering health care provider regarding telemedicine findings;

(v) Coordination and referral to other medical providers as needed; and

(vi) Referral for an in-person visit or the emergency room as needed.

(11) The telemedicine equipment and network used for remote patient monitoring services should meet the following requirements:

(a) Comply with applicable standards of the United States Food and Drug Administration;

(b) Telehealth equipment be maintained in good repair and free from safety hazards;

(c) Telehealth equipment be new or sanitized before installation in the patient's home setting;

(d) Accommodate non-English language options; and

(e) Have 24/7 technical and clinical support services available for the patient user.

(12) All health insurance and employee benefit plans in this state must provide coverage and reimbursement for the asynchronous telemedicine services of store-and-forward telemedicine services and remote patient monitoring services based on the criteria set out in this section. Store-and-forward telemedicine services shall be reimbursed to the same extent that the services would be covered if they were provided through in-person consultation.

(13) Remote patient monitoring services shall include reimbursement for a daily monitoring rate at a minimum of Ten Dollars ($10.00) per day each month and Sixteen Dollars ($16.00) per day when medication adherence management services are included, not to exceed thirty-one (31) days per month. These reimbursement rates are only eligible to Mississippi-based telehealth programs affiliated with a Mississippi health care facility.

(14) A one-time telehealth installation/training fee for remote patient monitoring services will also be reimbursed at a minimum rate of Fifty Dollars ($50.00) per patient, with a maximum of two (2) installation/training fees/calendar year. These reimbursement rates are only eligible to Mississippi-based telehealth programs affiliated with a Mississippi health care facility.

(15) No geographic restrictions shall be placed on the delivery of telemedicine services in the home setting other than requiring the patient reside within the State of Mississippi.

(16) Health care providers seeking reimbursement for store-and-forward telemedicine services must be licensed Mississippi providers that are affiliated with an established Mississippi health care facility in order to qualify for reimbursement of telemedicine services in the state. If a service is not available in Mississippi, then a health insurance or employee benefit plan may decide to allow a non-Mississippi-based provider who is licensed to practice in Mississippi reimbursement for those services.

(17) A health insurance or employee benefit plan may charge a deductible, co-payment, or coinsurance for a health care service provided through store-and-forward telemedicine services or remote patient monitoring services so long as it does not exceed the deductible, co-payment, or coinsurance applicable to an in-person consultation.

(18) A health insurance or employee benefit plan may limit coverage to health care providers in a telemedicine network approved by the plan.

(19) Nothing in this section shall be construed to prohibit a health insurance or employee benefit plan from providing coverage for only those services that are medically necessary, subject to the terms and conditions of the covered person's policy.

(20) In a claim for the services provided, the appropriate procedure code for the covered service shall be included with the appropriate modifier indicating telemedicine services were used. A "GQ" modifier is required for asynchronous telemedicine services such as store-and-forward and remote patient monitoring.

(21) The originating site is eligible to receive a facility fee, but facility fees are not payable to the distant site.

HISTORY: Laws, 2014, ch. 436, § 1, eff from and after July 1, 2014; Laws, 2021, ch. 305, § 1, eff from and after July 1, 2021.

Amendment Notes — The 2021 amendment, in (5), deleted former (b), which read: "Have a recent history of costly service use due to one or more chronic conditions as evidenced by two (2) or more hospitalizations, including emergency room visits, in the last twelve (12) months; and," redesignated former (c) as (b), and made a related change; and in (6), rewrote the introductory paragraph, which read: "A remote patient monitoring prior authorization request form must be submitted to request telemonitoring services. The request must include the following."

CHAPTER 11.

AUTOMOBILE INSURANCE

Article 1. Cancellation or Nonrenewal of Policy. 83-11-1
Article 3. Uninsured Motorist Coverage. 83-11-101
Article 5. Automobile Club Services. 83-11-201
Article 7. Towing and Storage of Disabled Vehicles. 83-11-301
Article 9. Repairs to Damaged Vehicles. 83-11-501
Article 11. Payment of Claims. 83-11-551

Cross References — Exclusion of legal services provided under automobile liability insurance policy from provisions relating to legal expense insurance, see § 83-49-5.

ARTICLE 1.

CANCELLATION OR NONRENEWAL OF POLICY.

Sec.
83-11-1. Definitions.
83-11-3. Grounds for cancellation and exceptions.
83-11-5. Notice of cancellation.
83-11-7. Non-renewal.
83-11-9. Proof of notice.
83-11-11. Notice of insured's eligibility for assigned risk plan.
83-11-13. Written statement of reasons for cancellation.
83-11-15. Liability for statement of reasons for cancellation.
83-11-17. Appeal from cancellation or nonrenewal.
83-11-19. Hearing and order of commissioner.
83-11-21. Judicial appeals from commissioner's decisions.

§ 83-11-1. Definitions.

As used in this article:

(a) "Policy" means an automobile liability, automobile physical damage, or automobile collision policy, or any combination thereof, delivered or issued for delivery in this state, insuring a single individual, or husband and wife resident of the same household, as named insured and under which the insured vehicles therein designated are of the following types only:

(i) A motor vehicle of the private passenger or station wagon type that is not used as a public or livery conveyance for passengers, nor rented to others; or

(ii) Any other four-wheel motor vehicle with a load capacity of fifteen hundred (1500) pounds or less which is not used in the occupation, profession, or business of the insured; provided, however, that this article shall not apply 1. to any policy issued under an automobile assigned risk plan, 2. to any policy insuring more than four (4) automobiles, or 3. to any policy covering garage, automobile sales agency, repair shop, service station, or public parking place operation hazards.

(b) "Automobile liability coverage" includes only coverage of bodily injury and property damage liability, medical payments, and uninsured motorist coverage.

(c) "Automobile physical damage coverage" includes all coverage of loss or damage to an automobile insured under the policy except loss or damage resulting from collision or upset.

(d) "Automobile collision coverage" includes all coverage of loss or damage to an automobile insured under the policy resulting from collision or upset.

(e) "Renewal" or "to renew" means the issuance and delivery by an insurer of a policy providing the same or substantially similar coverage replacing at the end of the policy period a policy previously issued and delivered by the same insurer or a licensed affiliate, or the issuance and delivery of a certificate of notice extending the term of a policy beyond its policy period or term; provided, however, that any policy with a policy period or term of less than six (6) months shall for the purpose of this article be considered as if written for a policy period or term of six (6) months. Any policy written for a term longer than one (1) year or any policy with no fixed expiration date shall, for the purpose of this article, be considered as if written for successive policy periods or terms of one (1) year; and such policy may be terminated at the expiration of any annual period upon giving thirty (30) days' notice of cancellation prior to such anniversary date. Such cancellation shall not be subject to any other provisions of this article.

(f) "Nonpayment of premium" means failure of the named insured to discharge when due any of his obligations in connection with the payment of premiums on a policy, or any installment of such premium, whether the premium is payable directly to the insurer or its agents or indirectly under any premium finance plan or extension of credit.

(g) "Affiliate transfer" is when an insurer transfers, at renewal or policy expiration, its personal or commercial lines insurance policies to an affiliated licensed insurer that is a member of the same insurance group or same holding company as the transferring insurer. The issuance of a replacement policy form providing the same or substantially similar coverage issued by the same insurer, or the transfer of personal or commercial insurance policies to a licensed affiliate insurer that will issue the same or substantially similar policy, are considered a renewal and will not be treated as a cancellation or nonrenewal. The affiliate transfer must be to a licensed affiliate insurer that has been determined by the commissioner to have the same or better financial strength as the transferring insurer. The policy transfer must be selected on a nondiscriminatory basis.

(h) "Substantially similar" means a policy that provides the same basic coverages but may add, alter or eliminate incidental coverages and may provide coverages using different textual language.

HISTORY: Codes, 1942, § 5670.8-101; Laws, 1970, ch. 450, § 1, eff 90 days after passage (approved April 2, 1970); Laws, 2018, ch. 312, § 1, eff from and after July 1, 2018.

JUDICIAL DECISIONS

1. Nonrenewal held proper.

In a declaratory judgment action filed by an insurer, as the policy unambiguously required that the premium payment had to be in the insurer's possession by a certain date, and it was undisputed that it never received the payment (though appellant claimed it was sent), the trial court properly granted the insurer summary judgment and found there was no coverage. Lynch v. Miss. Farm Bureau Cas. Ins. Co., 880 So. 2d 1065, 2004 Miss. App. LEXIS 254 (Miss. Ct. App. 2004).

In a declaratory judgment action filed by an insurer alleging that there was no coverage because the insurer had not received a premium payment, appellants' estoppel defense, based on the insurer's alleged failure to send a termination notice, failed, and the insurer was properly granted summary judgment; appellant could not have relied on the insurer's previous notice of termination letters because her husband, who made the payments, testified that he was never late with a premium payment. Lynch v. Miss. Farm Bureau Cas. Ins. Co., 880 So. 2d 1065, 2004 Miss. App. LEXIS 254 (Miss. Ct. App. 2004).

RESEARCH REFERENCES

ALR.

Limitation of amount of coverage under automobile liability policy as affected by fact that policy covers more than one vehicle. 37 A.L.R.3d 1263.

Construction and application of provision of automobile liability policy expressly excluding from coverage liability arising from actions between fellow employees. 45 A.L.R.3d 288.

What constitutes "trailer" within coverage or exclusion provision of automobile liability policy. 65 A.L.R.3d 804.

"Vehicle" or "land vehicle" within meaning of insurance policy provision defining risks covered or excepted. 65 A.L.R.3d 824.

Insured's right to bring direct action against insurer for uninsured motorist benefits. 73 A.L.R.3d 632.

Who is "named insured" within meaning of automobile insurance. 91 A.L.R.3d 1280.

Necessity or permissibility of naming no-fault insurer as defendant where insured automobile owner or operator is not liable for economic losses under no-fault insurance law. 40 A.L.R.4th 858.

Injury or death caused by assault as within coverage of no-fault motor vehicle insurance. 44 A.L.R.4th 1010.

Who is "employed or engaged in the automobile business" within exclusionary clause of liability policy. 55 A.L.R.4th 261.

What constitutes "motor vehicle" for purposes of no-fault insurance. 73 A.L.R.4th 1053.

Validity, construction, and application of provision in automobile liability policy excluding from coverage injury to, or death of, employee of insured. 43 A.L.R.5th 149.

Conflict of laws in determination of coverage under automobile liability insurance policy. 110 A.L.R.5th 465.

Am. Jur.

7 Am. Jur. 2d, Automobile Insurance § 1.

CJS.

44 C.J.S., Insurance § 59.

Law Reviews.

Insurance: Enforceability of Automobile Business Exclusion to Automobile Liability Coverage. 53 Miss. L. J. 205.

Practice References.

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-11-3. Grounds for cancellation and exceptions.

(1) A notice of cancellation of a policy shall be effective only if it is based on one or more of the following reasons:

(a) nonpayment of premium;

(b) the driver's license or motor vehicle registration of the named insured, or of any other operator who either resides in the same household or customarily operates an automobile insured under the policy, has been under suspension or revocation during the policy period or, if the policy is a renewal, during its policy period or the one hundred eighty (180) days immediately preceding its effective date, unless within seven (7) days from the date of any such cancellation or suspension, the insured shall give insurer written notice of such revocation or suspension and shall direct the insurer to exclude from coverage under said policy the person whose license was so suspended or revoked; further use of the insured vehicle by an excluded driver shall be grounds for immediate cancellation of a policy; or

(c) failure to make timely payment of dues to, or to maintain membership in good standing with, a designated association, corporation, or other organization where the original issue of such policy or renewal was dependent upon such membership.

(2) This section shall not apply to any policy or coverage which has been in effect less than sixty (60) days at the time notice of cancellation is mailed or delivered by the insurer, unless it is a renewal policy.

(3) Modification of automobile physical damage coverage by the inclusion of a deductible not exceeding One Hundred Dollars ($100.00) shall not be deemed a cancellation of the coverage or of the policy.

(4) This section shall not apply to nonrenewal.

HISTORY: 1942, § 5670.8-102; Laws, 1970, ch. 450, § 2, eff 90 days after passage (approved April 2, 1970).

JUDICIAL DECISIONS

1. In general.

Sixty-day limit on cancellation of automobile insurance policy by insurer does not affect insurer's right to seek rescission for alleged misrepresentations by insured prior to issuance of policy. Chapman v. Safeco Ins. Co., 722 F. Supp. 285, 1989 U.S. Dist. LEXIS 10768 (N.D. Miss. 1989).

RESEARCH REFERENCES

ALR.

State regulation of insurer's nonacceptance, cancellation, or nonrenewal of, or increase in rate on, automobile insurance policy, based on driving record. 36 A.L.R.4th 1205.

Validity and construction of automobile insurance provision or statute automatically terminating coverage when insured obtains another policy providing similar coverage. 61 A.L.R.4th 1130.

Am. Jur.

7 Am. Jur. 2d, Automobile Insurance §§ 8-10.

3 Am. Jur. Legal Forms 2d, Automobile Insurance §§ 32:11 et seq. (cancellation and nonrenewal).

10 Am. Jur. Proof of Facts 3d 483, Ineffective Cancellation of Automobile Insurance Policy-Deficient Communication of Cancellation Notice.

11 Am. Jur. Proof of Facts 3d 131, Ineffective Cancellation of Automobile Insurance Policy-Deficient Form or Content of Cancellation Notice.

11 Am. Jur. Proof of Facts 3d 227, Ineffective Cancellation of Automobile Insurance Policy-Deficient Repayment or Tender of Unearned Premium.

CJS.

45 C.J.S., Insurance §§ 674-696.

§ 83-11-5. Notice of cancellation.

No notice of cancellation of a policy to which Section 83-11-3 applies shall be effective unless mailed or delivered by the insurer to the named insured and to any named creditor loss payee at least thirty (30) days prior to the effective date of cancellation; provided, however, that where cancellation is for nonpayment of premium at least ten (10) days' notice of cancellation accompanied by the reason therefor shall be given. Unless the reason accompanies or is included in the notice of cancellation, the notice of cancellation shall state or be accompanied by a statement that upon written request of the named insured, mailed or delivered to the insurer not less than fifteen (15) days prior to the effective date of cancellation, the insurer will specify the reason for such cancellation.

This section shall not apply to nonrenewal unless there is a named creditor loss payee.

HISTORY: Codes, 1942, § 5670.8-103; Laws, 1970, ch. 450, § 3; Laws, 1989, ch. 410, § 2; Laws, 2006, ch. 480, § 2, eff from and after July 1, 2006.

Cross References — Requirement of conformity with this section for cancellation of legal expense insurance, see § 83-49-13.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Negotiation of premium check.

1. In general.

Insurer had an arguable reason for its actions of canceling the insurance coverage after the insurer failed to pay a monthly premium because the Commissioner of Insurance's interpretation of Miss. Code Ann. § 83-11-5, that it was understood as a requirement of reminding customers at least 10 days in advance that they should either timely pay their premiums or make alternative arrangements before the coverage in place expires, was not contrary to the statute's plain language. Keys v. Safeway Ins. Co., 2011 U.S. Dist. LEXIS 13197 (S.D. Miss. Feb. 9, 2011).

Production of a certificate of mailing raised a rebuttable presumption that the notice of cancellation was mailed, and a mere denial by the insured that he did not receive the notice of cancellation was not sufficient to rebut the presumption. Branch v. State Farm Fire & Cas. Co., 759 So. 2d 430, 2000 Miss. App. LEXIS 2 (Miss. Ct. App. 2000).

If insurance company, by its habit of business, creates in mind of policy holder belief that payment may be delayed until demanded, or otherwise waives right to demand forfeiture, this is binding on company notwithstanding there may not have been compliance with express letter of policy, but that principle has no application unless custom or usage was one of which insured had knowledge and upon which he relied, and this must apply equally to all types of insurance relationships. Stephen R. Ward, Inc. v. United States Fidelity & Guaranty Co., 681 F. Supp. 389, 1988 U.S. Dist. LEXIS 1902 (S.D. Miss. 1988).

Proof of mailing satisfies the notice requirement of § 83-11-5 for cancellation of an insurance policy. Thus, a certificate of mailing of a notice of cancellation to an insured at the address shown on an automobile insurance policy was sufficient proof of notice, and cancellation of the policy was effective, even though the insured denied that he ever received notice. State Farm Ins. Co. v. Gay, 526 So. 2d 534, 1988 Miss. LEXIS 304 (Miss. 1988).

Argument that automobile liability policy was ineffective because premium was not paid failed, when the jury could have found that the insured had a billing and credit arrangement with his agent which made the nonpayment irrelevant and no notice of cancellation of the policy had been given as required by this section. Henderson v. United States Fidelity & Guaranty Co., 620 F.2d 530, 1980 U.S. App. LEXIS 15986 (5th Cir. Miss.), cert. denied, 449 U.S. 1034, 101 S. Ct. 608, 66 L. Ed. 2d 495, 1980 U.S. LEXIS 4272 (U.S. 1980).

Under this section, notice of cancellation for nonpayment of a premium must be given at least ten days before the effective date of the cancellation and the timeliness of such notice must be determined by the date of its receipt rather than by the date of its mailing; if cancellation is for a reason other than nonpayment, the notice may be mailed or delivered at least 20 days before the cancellation date. Black v. Fidelity & Guaranty Ins. Underwriters, Inc., 582 F.2d 984, 1978 U.S. App. LEXIS 8132 (5th Cir. Miss. 1978).

2. Negotiation of premium check.

An insurance company was not equitably estopped from denying coverage due to the fact that it negotiated a premium check that the insureds had belatedly sent after receiving a proper notice of cancellation, prior to sending them a refund; the insureds' failure to mail a check in a timely manner was their responsibility alone and the mere negotiation of the refund check could not have given rise to a reasonable belief on the part of the insureds that their policy was still in effect, even assuming, purely arguendo, that they were aware of such negotiation at the time of their accident. Brown v. Progressive Gulf Ins. Co., 761 So. 2d 134, 2000 Miss. LEXIS 36 (Miss. 2000).

RESEARCH REFERENCES

ALR.

Actual receipt of cancellation notice mailed by insurer as prerequisite to cancellation of insurance. 40 A.L.R.4th 867.

Am. Jur.

7 Am. Jur. 2d, Automobile Insurance § 10.

3 Am. Jur. Legal Forms 2d, Automobile Insurance §§ 32:11 et seq. (cancellation and nonrenewal).

10 Am. Jur. Proof of Facts 3d 483, Ineffective Cancellation of Automobile Insurance Policy-Deficient Communication of Cancellation Notice.

11 Am. Jur. Proof of Facts 3d 131, Ineffective Cancellation of Automobile Insurance Policy-Deficient Form or Content of Cancellation Notice.

11 Am. Jur. Proof of Facts 3d 227, Ineffective Cancellation of Automobile Insurance Policy-Deficient Repayment or Tender of Unearned Premium.

CJS.

45 C.J.S., Insurance § 653, 687-690.

§ 83-11-7. Non-renewal.

No insurer shall fail to renew a policy unless it shall mail or deliver to the named insured, at the address shown in the policy and to the named creditor loss payee, at least thirty (30) days' advance notice of its intention not to renew. This section shall not apply if there is no named creditor loss payee and:

(a) If the insurer has manifested its willingness to renew, subject to certain specified conditions which are not met by the insured; nor

(b) If the insured has manifested its unwillingness to renew; nor

(c) In case of nonpayment of premium; nor

(d) In case of failure to make timely payment of dues to, or to maintain membership in good standing with, a designated association, corporation or other organization where the original issue of such policy or renewal was dependent upon such membership; provided that, notwithstanding the failure of an insurer to comply with this section, the policy shall terminate on the effective date of any other insurance policy with respect to any automobile designated in both policies.

A notice of nonrenewal is not required when a replacement policy form is issued by the same insurer or when an insured is transferred to a licensed affiliate of the insurer, so long as the transfer or replacement results in the same or substantially similar coverage. Whenever a replacement policy form is issued by the same insurer, or when transfer of an insured to a licensed affiliate occurs documents signed by the insured are applicable to the replacement policy form, the coverage transferred to a licensed affiliate insurer, or both, and remain valid and enforceable.

Whenever a replacement policy form providing the same or substantially similar coverage is issued by the same insurer, or by a licensed affiliate insurer, such insurer shall mail or deliver to the policyholder, at least thirty (30) days in advance of the effective date of renewal, written notice of any terms or conditions that are less favorable to the policyholder.

A transferring insurer shall notify the Mississippi Insurance Department at least forty-five (45) days in advance of notifying a policyholder that its personal or commercial lines insurance policies will be transferred to another licensed insurer within the same insurance group or same holding company. The notice shall include the name of insurer transferring the personal or commercial lines policies and the name and financial rating of the insurer receiving the transferred personal or commercial lines policies.

A transferring insurer shall provide the policyholder written notice of the policy transfer at least thirty (30) days prior to expiration of the policy term and shall include the financial rating of the insurer receiving the transferred policy. Such notice must be provided to the policyholder with the notice of renewal premium at least thirty (30) days before the effective date of the transfer.

Renewal of a policy shall not constitute a waiver or estoppel with respect to grounds for cancellation which existed before the effective date of such renewal, and if a policy shall be cancelled as authorized by this article prior to such policy's renewal, such cancellation shall terminate any right of renewal conferred by this article.

HISTORY: Codes, 1942, § 5670.8-104; Laws, 1970, ch. 450, § 4; Laws, 2006, ch. 480, § 3, eff from and after July 1, 2006; Laws, 2018, ch. 312, § 2, eff from and after July 1, 2018.

JUDICIAL DECISIONS

1. In general.

Failure of an insurer to provide the bank, which loaned money to the insured for the purchase of an automobile, with notice of the insurer's non-renewal of the insured's automobile insurance policy did not provide the insured with any rights or cause of action regarding the policy coverage. Alexander v. Aig Agency Auto, Inc, 138 So. 3d 190, 2013 Miss. App. LEXIS 865 (Miss. Ct. App. 2013).

Where insurance company manifests willingness to renew insurance policy by language in policy indicating that nonpayment of premiums or loss of driver's license would be only grounds for cancellation, but policy also provides for insurer's right to choose not to renew policy for nonpayment of premiums, insurer does not have to send insured cancellation notice upon failure to receive premium payment within specified time, such nonpayment may be treated as nonrenewal. Estate of Beinhauer v. Aetna Casualty & Surety Co., 893 F.2d 782, 1990 U.S. App. LEXIS 1477 (5th Cir. Miss. 1990).

If insurance company, by its habit of business, creates in mind of policy holder belief that payment may be delayed until demanded, or otherwise waives right to demand forfeiture, this is binding on company notwithstanding there may not have been compliance with express letter of policy, but that principle has no application unless custom or usage was one of which insured had knowledge and upon which he relied, and this must apply equally to all types of insurance relationships. Stephen R. Ward, Inc. v. United States Fidelity & Guaranty Co., 681 F. Supp. 389, 1988 U.S. Dist. LEXIS 1902 (S.D. Miss. 1988).

Section 83-11-7 is directed to situation where insurer has made conscious decision not to renew policy at expiration date, and does not address issue whether notice is required before existing policy expires when insurer is willing to renew policy but has not been contacted by insured regarding any renewal; good faith reliance by insurer on advice of counsel prevents imposition of punitive damages. Gorman v. Southeastern Fidelity Ins. Co., 775 F.2d 655, 1985 U.S. App. LEXIS 24578 (5th Cir. Miss. 1985).

Insurer is not liable for punitive damages as result of its refusal to pay claim where it had arguable reason for denial, since, as of time of dispute, issue of whether notice of its intention not to renew policy was required as matter of law under facts of case had never been determined, and where defendant's denial of payment was based upon advice of counsel. Gorman v. Southeastern Fidelity Ins. Co., 621 F. Supp. 33, 1985 U.S. Dist. LEXIS 21113 (S.D. Miss.), aff'd, 775 F.2d 655, 1985 U.S. App. LEXIS 24578 (5th Cir. Miss. 1985).

Automobile insurance coverage lapses, in accordance with provisions of insurance policy and renewal and premium due notices sent insured, where insured fails to make timely payment of renewal premium, notwithstanding insured's tender of renewal premium following automobile accident occurring three weeks after expiration of policy. Willis v. Mississippi Farm Bureau Mut. Ins. Co., 481 So. 2d 256, 1985 Miss. LEXIS 2423 (Miss. 1985).

RESEARCH REFERENCES

ALR.

Insured's right of action for arbitrary nonrenewal of policy, where insurer has option not to renew. 37 A.L.R.4th 862.

Am. Jur.

3 Am. Jur. Legal Forms 2d, Automobile Insurance §§ 32:11 et seq. (cancellation and nonrenewal).

CJS.

44 C.J.S., Insurance §§ 457-459 et seq.

§ 83-11-9. Proof of notice.

Proof of mailing of notice of cancellation, or of intention not to renew, or of reasons for cancellation to the named insured by a certificate of mailing, at the address shown in the policy, shall be sufficient proof of notice.

HISTORY: Codes, 1942, § 5670.8-105; Laws, 1970, ch. 450, § 5, eff 90 days after passage (approved April 2, 1970).

Cross References — Requirement of conformity with this section for cancellation of legal expense insurance, see § 83-49-13.

JUDICIAL DECISIONS

1. In general.

Insurer was entitled to summary judgment on an insured's coverage claim because the certificate of mailing which the insurer provided was conclusive proof of the insured's receipt of notice of the cancellation by the insurer of the insured's automobile insurance policy, and the insured failed to provide sufficient evidence to create a triable issue of fact to overcome the presumption of notice. Alexander v. Aig Agency Auto, Inc, 138 So. 3d 190, 2013 Miss. App. LEXIS 865 (Miss. Ct. App. 2013).

Production of a certificate of mailing raised a rebuttable presumption that the notice of cancellation was mailed, and a mere denial by the insured that he did not receive the notice of cancellation was not sufficient to rebut the presumption. Branch v. State Farm Fire & Cas. Co., 759 So. 2d 430, 2000 Miss. App. LEXIS 2 (Miss. Ct. App. 2000).

Production of a "certificate of mailing" does not constitute conclusive proof of an insured's actual receipt of a cancellation notice. A certificate of mailing establishes a presumption that the notice reached its destination. However, this presumption may be rebutted by the insured who contends that he or she did not actually receive the notice, though mere denial of receipt is insufficient to create a triable issue of fact. In other words, proof of mailing of a notice of cancellation is sufficient proof of notice absent countervailing evidence of sufficient weight to rebut the presumption that it was received. Carter v. Allstate Indem. Co., 592 So. 2d 66, 1991 Miss. LEXIS 872 (Miss. 1991).

Premium notice carrying statement at top of page that for continuous protection, payment must be mailed prior to date due, is sufficient to meet requirements of § 83-11-9. Willis v. Mississippi Farm Bureau Mut. Ins. Co., 481 So. 2d 256, 1985 Miss. LEXIS 2423 (Miss. 1985).

In a second trial on a punitive damages claim against an insurer, the trial court's remark that the insurer's testimony regarding whether a cancellation notice was mailed was irrelevant because the insured never received it was not prejudicial to defendant and was clearly accurate, since the issue of whether a cancellation notice was given had already been conclusively determined in the first trial between the same parties. Henderson v. United States Fidelity & Guaranty Co., 695 F.2d 109, 1983 U.S. App. LEXIS 27663 (5th Cir. Miss. 1983).

RESEARCH REFERENCES

ALR.

Actual receipt of cancellation notice mailed by insurer as prerequisite to cancellation of insurance. 40 A.L.R.4th 867.

Am. Jur.

43 Am. Jur. 2d, Insurance § 434.

10 Am. Jur. Proof of Facts 3d 483, Ineffective Cancellation of Automobile Insur-

ance Policy-Deficient Communication of Cancellation Notice.

11 Am. Jur. Proof of Facts 3d 131, Ineffective Cancellation of Automobile Insurance Policy-Deficient Form or Content of Cancellation Notice.

11 Am. Jur. Proof of Facts 3d 227, Ineffective Cancellation of Automobile Insurance Policy-Deficient Repayment or Tender of Unearned Premium.

CJS.

45 C.J.S., Insurance § 653, 687-690.

§ 83-11-11. Notice of insured's eligibility for assigned risk plan.

When a policy of automobile liability insurance is cancelled other than for nonpayment of premium, or in the event of failure to renew a policy of automobile liability insurance to which Section 83-11-7 applies, the insurer shall notify the named insured of his possible eligibility for automobile liability insurance through the automobile liability assigned risk plan. Such notice shall accompany or be included in the notice of cancellation or the notice of intent not to renew.

HISTORY: Codes, 1942, § 5670.8-106; Laws, 1970, ch. 450, § 6, eff 90 days after passage (approved April 2, 1970).

RESEARCH REFERENCES

Am. Jur.

7 Am. Jur. 2d, Automobile Insurance §§ 9, 10, 36.

§ 83-11-13. Written statement of reasons for cancellation.

Where the reason for cancellation does not accompany or is not included in the notice of cancellation, the insurer shall, upon written request of the named insured mailed or delivered to the insurer not less than fifteen (15) days prior to the effective date of cancellation, specify in writing the reason for such cancellation. Such reason shall be mailed or delivered to the named insured within five (5) days after receipt of such request.

HISTORY: Codes, 1942, § 5670.8-107; Laws, 1970, ch. 450, § 7, eff 90 days after passage (approved April 2, 1970).

Cross References — Requirement of conformity with this section for cancellation of legal expense insurance, see § 83-49-13.

RESEARCH REFERENCES

Am. Jur.

7 Am. Jur. 2d, Automobile Insurance §§ 8-10.

CJS.

45 C.J.S., Insurance §§ 674-696.

§ 83-11-15. Liability for statement of reasons for cancellation.

There shall be no liability on the part of and no cause of action of any nature shall arise against the commissioner of insurance or against any insurer, its authorized representative, its agents, its employees, or any firm, person, or corporation furnishing to the insurer or its agents information as to reasons for cancellation, for any statement made by any of them in any written notice of cancellation or in any other communication, oral or written, specifying the reasons for cancellation or the providing of information pertaining thereto, or for statements made or evidence submitted at any hearings conducted in connection therewith.

HISTORY: Codes, 1942, § 5670.8-108; Laws, 1970, ch. 450, § 8, eff 90 days after passage (approved April 2, 1970).

Cross References — Requirement of conformity with this section for cancellation of legal expense insurance, see § 83-49-13.

RESEARCH REFERENCES

Am. Jur.
7 Am. Jur. 2d, Automobile Insurance §§ 8-10.

CJS.
45 C.J.S., Insurance §§ 674-696.

§ 83-11-17. Appeal from cancellation or nonrenewal.

A named insured who wishes to contest the reason or reasons for a cancellation of a policy which has been in effect for sixty (60) days or more or failure by insurer to give proper notice of nonrenewal as provided hereunder shall, not less than seven (7) working days from the date of receipt of notice of cancellation or receipt of notice of nonrenewal, mail or deliver to the Commissioner of Insurance a written request for a hearing, which request shall state clearly the basis for the appeal and shall be accompanied by a filing fee of Fifteen Dollars ($15.00).

A cancellation or nonrenewal which is subject to the provisions of this article shall be deemed effective unless the Commissioner of Insurance determines otherwise in accordance with the provisions of this article.

HISTORY: Codes, 1942, § 5670.8-109; Laws, 1970, ch. 450, § 9; Laws, 1998, ch. 416, § 1, eff from and after July 1, 1998.

Cross References — Requirement of conformity with this section for cancellation of legal expense insurance, see § 83-49-13.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 472-476.
10 Am. Jur. Proof of Facts 3d 483, Ineffective Cancellation of Automobile Insurance Policy-Deficient Communication of Cancellation Notice.
11 Am. Jur. Proof of Facts 3d 131, Ineffective Cancellation of Automobile Insur-

ance Policy-Deficient Form or Content of Cancellation Notice.

11 Am. Jur. Proof of Facts 3d 227, Ineffective Cancellation of Automobile Insurance Policy-Deficient Repayment or Tender of Unearned Premium.

CJS.

45 C.J.S., Insurance §§ 721-738.

§ 83-11-19. Hearing and order of commissioner.

Within two (2) working days after receipt of a timely request for a hearing, the commissioner or his officially appointed designee shall call a hearing upon at least seven (7) days' notice to the parties. Each insurer licensed to do in this state the kind of business which is subject to this article shall maintain on file with the commissioner the name and address of the person authorized to receive notices pursuant to this article on behalf of the insurer.

The commissioner or his designated representative who conducted the hearing shall, at the conclusion thereof or not later than two (2) days thereafter, issue his written findings to the parties. If he finds for the named insured, he shall assess the insurer Fifteen Dollars ($15.00) to defray the cost of the hearing and shall refund the Fifteen Dollars ($15.00) filing fee to the named insured; and he shall either order the insurer to rescind its notice of cancellation or, if the date cancellation is to be effective has elapsed, order the policy reinstated or renewed. Such order shall operate retroactively only to cover a period not to exceed twenty (20) days from the date cancellation otherwise would have been effective, and prospectively from the date on which the order was issued; provided, however, that no policy shall be reinstated or renewed while the named insured is in arrears in payment of premiums on such policy. If the commissioner or his representative finds for the insurer, his written order shall so state and he shall assess the named insured Fifteen Dollars ($15.00) and apply the named insured's Fifteen Dollar ($15.00) filing fee against the assessment to defray the cost of the hearing. Reinstatement of a policy under this section shall not operate in any way to extend the expiration, termination, or anniversary date provided in the policy. Renewal of a policy shall be for a term of one (1) year from the expiration date of the prior policy, and otherwise shall contain the same coverage, terms, and contractual provisions contained in said prior policy.

HISTORY: Codes, 1942, § 5670.8-110; Laws, 1970, ch. 450, § 10, eff 90 days after passage (approved April 2, 1970).

Cross References — Requirement of conformity with this section for cancellation of legal expense insurance, see § 83-49-13.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 472 et seq.

CJS.

45 C.J.S., Insurance §§ 721-729 et seq.

§ 83-11-21. Judicial appeals from commissioner's decisions.

The following procedure shall govern in taking and perfecting appeals from the decision of the commissioner:

(a) Any person who is a party to any hearing before the commissioner, and who is aggrieved by any decision of the commissioner with respect to any hearing before him, shall have the right of appeal to the chancery court of the county of the insured's residence. All such appeals shall be taken and perfected within sixty (60) days from the date of the decision of the commissioner which is the subject of the appeal, and the chancery court to which such appeal is taken may affirm such decision, or reverse and remand the same to the commissioner for further proceedings as justice may require, or dismiss such appeal. All such appeals shall be tried de novo.

(b) Upon the filing with the commissioner of a petition of appeal to the proper chancery court, it shall be the duty of the commissioner, as promptly as possible and in any event within sixty (60) days after approval of the appeal bond, to file with the clerk of said chancery court to which the appeal is taken a copy of the petition for appeal and of the decision appealed from, and the original and one (1) copy of the transcript of the record of the proceedings and evidence before the commission. After the filing of said petition, the appeal shall be perfected by the filing of a bond in the penal sum of One Hundred Dollars ($100.00) with two (2) sureties, or with a surety company qualified to do business in Mississippi as surety, conditioned to pay the costs of such appeal, said bond to be approved by the commissioner or by the clerk of the chancery court to which such appeal is taken.

(c) No decision of the commissioner made as a result of a hearing under the provisions of this section shall become final with respect to any party affected and aggrieved by such decision until such party shall have exhausted or shall have had an opportunity to exhaust all of his remedies provided by this section.

HISTORY: Codes, 1942, § 5670.8-111; Laws, 1970, ch. 450, § 11, eff 90 days after passage (approved April 2, 1970).

Cross References — Requirement of conformity with this section for cancellation of legal expense insurance, see § 83-49-13.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

ARTICLE 3.

UNINSURED MOTORIST COVERAGE.

Sec.
83-11-101. Automobile liability policies to contain "uninsured motorist" and property damage provisions; rejection of uninsured motorist coverage.

Sec.
83-11-102. Purchase of single-limit, nonstacking uninsured motorist insurance coverage for four or more vehicles in lieu of uninsured motorists coverage for each vehicle.
83-11-103. Definitions.
83-11-105. Action against owner or operator of uninsured vehicle.
83-11-107. Subrogation.
83-11-109. Arbitration provisions prohibited.
83-11-111. Excess insurance coverage.

§ 83-11-101. Automobile liability policies to contain "uninsured motorist" and property damage provisions; rejection of uninsured motorist coverage.

(1) No automobile liability insurance policy or contract shall be issued or delivered after January 1, 1967, unless it contains an endorsement or provisions undertaking to pay the insured all sums which he shall be legally entitled to recover as damages for bodily injury or death, or would be legally entitled to recover as damages for bodily injury or death but for the immunity provided under the Mississippi Tort Claims Act, from the owner or operator of an uninsured motor vehicle, within limits which shall be no less than those set forth in the Mississippi Motor Vehicle Safety Responsibility Law, as amended, under provisions approved by the Commissioner of Insurance; however, at the option of the insured, the uninsured motorist limits may be increased to limits not to exceed those provided in the policy of bodily injury liability insurance of the insured or such lesser limits as the insured elects to carry over the minimum requirement set forth by this section. The coverage herein required shall not be applicable where any insured named in the policy shall reject the coverage in writing and provided further, that unless the named insured requests such coverage in writing, such coverage need not be provided in any renewal policy, any replacement policy with the same or substantially similar terms and conditions issued by the same insurer, and any transferred policy with the same or substantially similar terms and conditions issued by a licensed affiliate of the original insurer where the named insured had rejected the coverage in connection with a policy previously issued to him by the same insurer or a licensed affiliate of the original insurer in the same holding company.

(2) No automobile liability insurance policy or contract shall be issued or delivered after January 1, 1980, unless it contains an endorsement or provisions undertaking to pay the insured all sums which he shall be legally entitled to recover as damages for property damage, or would be legally entitled to recover as damages for property damage but for the immunity provided under the Mississippi Tort Claims Act, from the owner or operator of an uninsured motor vehicle, within limits which shall be no less than those set forth in the Mississippi Motor Vehicle Safety Responsibility Law, as amended, under provisions approved by the Commissioner of Insurance; however, at the option of the insured, the uninsured motorist limits may be increased to limits not to exceed those provided in the policy of property damage liability insurance of

the insured or such lesser limits as the insured elects to carry over the minimum requirement set forth by this section. The coverage herein required shall not be applicable where any insured named in the policy shall reject the coverage in writing and provided further, that unless the named insured requests such coverage in writing, such coverage need not be provided in any renewal policy, any replacement policy with the same or substantially similar terms and conditions issued by the same insurer, and any transferred policy with the same or substantially similar terms and conditions issued by a licensed affiliate of the original insurer where the named insured had rejected the coverage in connection with a policy previously issued to him by the same insurer or a licensed affiliate of the original insurer in the same holding company.

The property damage provision may provide an exclusion for the first Two Hundred Dollars ($200.00) of such property damage; however, the uninsured motorist provision need not insure any liability for property damage, for which loss the policyholder has been compensated by insurance or otherwise.

(3) The insured may reject the property damage liability insurance coverage required by subsection (2) and retain the bodily injury liability insurance coverage required by subsection (1), but if the insured rejects the bodily injury liability coverage he may not retain the property damage liability coverage. No insured may have property damage liability insurance coverage under this section unless he also has bodily injury liability insurance coverage under this section.

(4) In the course of the sale or issuance of any automobile liability insurance policy, insurers shall inform the named insured or applicant, on a form approved by the Department of Insurance, of the benefits of and reasons for electing to purchase uninsured motorist coverage. If the insured named in the policy wishes to reject uninsured motorist coverage, such form shall be signed by or on behalf of the named insured. If this form is signed by or on behalf of the named insured, it is binding upon all persons insured by the automobile liability insurance policy and it shall be presumed that there was an informed, knowing rejection and waiver of uninsured motorist coverage.

HISTORY: Codes, 1942, § 8285-51; Laws, 1966, ch. 524, § 1; Laws, 1974, ch. 393; Laws, 1979, chs. 429 § 2, 432; Laws, 2014, ch. 428, § 1, eff from and after July 1, 2014; Laws, 2018, ch. 312, § 5, eff from and after July 1, 2018; Laws, 2020, ch. 305, § 1, eff from and after passage (approved June 10, 2020).

Cross References — Motor Vehicle Safety Responsibility Law, see §§ 63-15-1 et seq.

Application of this section to the exemption from liability of volunteers and sports officials, see § 95-9-5.

JUDICIAL DECISIONS

ANALYSIS

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1. In general.

Because plaintiff's negligence claim against a county failed as a matter of law, so did his claim against his insurance carrier for uninsured motorist benefits. Plaintiff's failure to make a prima facie showing of negligence disposed of all claims against both defendants. Robinson v. Holmes Cty., 284 So. 3d 730, 2019 Miss. LEXIS 348 (Miss. 2019).

Purpose of Miss. Code Ann. § 83-11-101(2) is to provide protection to innocent insured motorists and passengers injured as a result of the negligence of financially irresponsible drivers; the intent is to provide the same protection to one injured by an uninsured motorist as that individual would have if injured by a financially responsible driver. Jones v. Southern United Fire Ins., 935 So. 2d 1127, 2006 Miss. App. LEXIS 565 (Miss. Ct. App. 2006).

In a family's wrongful death suit against the department of motor vehicles and the decedents' insurer, based upon the remedial purposes of Mississippi's Uninsured Motorist Act, Miss. Code Ann. § 83-11-101 et seq., and the stipulated damages which well exceeded the parties' settlement, the family was entitled to receive uninsured motorist benefits from the insurer. Alfa Ins. Corp. v. Ryals, 918 So. 2d 676, 2004 Miss. App. LEXIS 560 (Miss. Ct. App. 2004), rev'd, 918 So. 2d 1260, 2005 Miss. LEXIS 442 (Miss. 2005).

Employer's (insured's) policy never rejected uninsured motorists coverage, but it limited the protection to those vehicles the employer owned, and there was a written application for limited coverage made by the insured through its agent; the appellate court interpreted the statutory right to reject coverage in writing to encompass the lesser act of limiting that coverage, and that was sufficient insofar as the employer was concerned. Trotter v. Fed. Ins. Co., 865 So. 2d 411, 2004 Miss. App. LEXIS 107 (Miss. Ct. App. 2004).

Trial court erred by denying the insurer summary judgment in the employee's suit to enforce uninsured motorist coverage because a written rejection of coverage by the employer was not required to be maintained where the evidence indicated that the coverage had voluntarily been dropped prior to the accident. Travelers Prop. Cas. Corp. v. Stokes, 838 So. 2d 270, 2003 Miss. LEXIS 66 (Miss. 2003).

Mississippi's Uninsured Motorist Act (UM Act) was designed to fill three gaps in coverage that were left after enactment of Mississippi's Safety Responsibility Act: negligent drivers would often fail to purchase liability insurance mandated by law; denial of coverage on basis of uninsured motorist exclusions or policy breaches; and tortfeasor sometimes happened to be hit-and-run driver. Boatner v. Atlanta Specialty Ins. Co., 115 F.3d 1248, 1997 U.S. App. LEXIS 22634 (5th Cir. Miss. 1997).

Uninsured motorist (UM) policy terms that meet minimum requirements under Mississippi's Uninsured Motorist Act (UM Act), by definition, cannot run counter to Mississippi public policy. Boatner v. Atlanta Specialty Ins. Co., 115 F.3d 1248, 1997 U.S. App. LEXIS 22634 (5th Cir. Miss. 1997).

In enacting Mississippi's Uninsured Motorist Act (UM Act), Mississippi legislature intended to put "first accident" insureds in as good a position as they would have been in had uninsured motorist purchased automobile liability insurance pursuant to terms of Mississippi's Safety Responsibility Act. Boatner v. Atlanta Specialty Ins. Co., 115 F.3d 1248, 1997 U.S. App. LEXIS 22634 (5th Cir. Miss. 1997).

Hitchhiker was not "operator" of uninsured motor vehicle, so as to entitle estate of insured driver to uninsured motorist (UM) benefits when hitchhiker murdered driver; although hitchhiker told insured where to drive after pulling gun on insured, hitchhiker did not operate truck prior to murder and did not murder insured driver to gain use of vehicle. United Servs. Auto. Ass'n v. Shell, 698 So. 2d 96, 1997 Miss. LEXIS 323 (Miss. 1997).

Under § 83-11-101(1), uninsured motorist (UM) carrier was entitled to assert city's defense of sovereign immunity (§ 11-46-9) in connection with collision between fire truck and insured; insured's statutory right to UM benefits is limited to instances in which insured would be entitled, at time of injury, to recover through legal action. Coleman v. American Mfrs. Mut. Ins. Co., 930 F. Supp. 255, 1996 U.S. Dist. LEXIS 8961 (N.D. Miss. 1996).

Decision of federal district court sitting in Mississippi as to whether Mississippi insurance agents had duty to recommend uninsured motorist limits to insureds was not binding upon state Aetna Casualty & Sur. Co. v. Berry, 669 So. 2d 56, 1996 Miss. LEXIS 20 (Miss. 1996), overruled in part, Owens v. Miss. Farm Bureau Cas. Ins. Co., 910 So. 2d 1065, 2005 Miss. LEXIS 562 (Miss. 2005).

In order for insured to have option to increase uninsured motorist (UM) limits or for insured to completely reject UM coverage in writing, insurance agent has duty to explain UM coverage; agent is not under duty to recommend that insured exercise option to obtain UM coverage up to limits of policy, but before insured may make intelligent decision about how much UM coverage he or she wants, or make knowing waiver of coverage in writing, insured must understand what he or she is entitled to. Aetna Casualty & Sur. Co. v. Berry, 669 So. 2d 56, 1996 Miss. LEXIS 20 (Miss. 1996), overruled in part, Owens v. Miss. Farm Bureau Cas. Ins. Co., 910 So. 2d 1065, 2005 Miss. LEXIS 562 (Miss. 2005).

Language in an insurance policy limiting uninsured motorist (UM) coverage to damages arising "out of the ownership, maintenance or use of an uninsured motor vehicle" did not impermissibly narrow the limits of UM coverage intended under Mississippi's UM statute (§ 83-11-101 et seq.), since the policy language satisfied the intent of the UM statute by affording a person injured by an uninsured motorist the same protection he or she would have if injured by a financially responsible driver. Spradlin v. Atlanta Casualty Co., 650 So. 2d 1389, 1995 Miss. LEXIS 91 (Miss. 1995).

Language in an insurance policy limiting uninsured motorist (UM) coverage to injury or damage caused by an accident "arising out of the operation, maintenance or use of an uninsured motor vehicle" did not impermissibly narrow the limits of UM coverage intended under Mississippi's UM statute (§ 83-11-101 et seq.); although the UM statute does not specifically set out the connection that must exist between the injury and the uninsured vehicle, § 83-11-101 states that the limits of UM coverage shall be no less than those set forth in the Motor Vehicle Safety Responsibility Law (§ 63-15-1 et seq.), which provides in part that an owner's liability insurance policy which has been certified as proof of financial responsibility shall pay damages "arising out of the ownership, maintenance or use of such motor vehicle" (§ 63-15-43(2)(b)), and therefore the UM policy language satisfied the intent and purpose of the UM statute by affording a person injured by an uninsured motorist the same protection he or she would have if injured by a financially responsible driver. Spradlin v. State Farm Mut. Auto. Ins. Co., 650 So. 2d 1383, 1995 Miss. LEXIS 93 (Miss. 1995).

The meaning of the phrase "legally entitled to recover" found in the Mississippi Uninsured Motorist Act (§§ 83-11-101 et seq) limits the scope of the coverage mandated by the statute to those instances in which the insured would be entitled at the time of injury to recover through legal action; there is no statutory mandate to provide coverage in instances where the alleged tortfeasor is immune from liability. Medders v. United States Fidelity & Guar. Co., 623 So. 2d 979, 1993 Miss. LEXIS 313 (Miss. 1993).

Under §§ 83-11-101 and 83-11-103, when an automobile owner accepts an insurer's offer of uninsured motorist coverage, both the owner and his or her guests are insured for bodily and property damage arising from the negligent operation of an uninsured vehicle. Brown v. Hartford Ins. Co., 606 So. 2d 122, 1992 Miss. LEXIS 558 (Miss. 1992).

A "named driver exclusion" endorsement in an automobile insurance policy, which specifically provides for the written rejection of uninsured motorist benefits, violates the Mississippi Uninsured Motorist Act (§§ 83-11-101 et seq.) so as to render the exclusion invalid. Atlanta Casualty Co. v. Payne, 603 So. 2d 343, 1992 Miss. LEXIS 388 (Miss. 1992).

The burden of proof is on the insurer to show that an exclusion limiting uninsured motorist coverage, or any other quasi-rejection of uninsured motorist insurance, was a knowing and informed decision. Atlanta Casualty Co. v. Payne, 603 So. 2d 343, 1992 Miss. LEXIS 388 (Miss. 1992).

There is no cause of action in Mississippi predicated on duty of insurance company or its agents to recommend uninsured motorist policy limits to applicants. Thomas v. State Farm Mut. Auto. Ins. Co., 796 F. Supp. 231, 1992 U.S. Dist. LEXIS 9432 (S.D. Miss. 1992).

Where uninsured motorist benefits were written into an assigned risk policy through operation of law, the imposed coverage would be the statutory minimum of $10,000 per vehicle, rather than the amount contracted in a previously canceled policy, where there was no evidence that either party intended to reinstate the policy limits contained in the former policy; since coverage was written into the contract by operation of law, so was the amount of coverage. Harris v. Magee, 573 So. 2d 646, 1990 Miss. LEXIS 900 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

An insurer was notified of a claim, which arose from an automobile accident between an insured and an uninsured motorist, well within the applicable 6-year statute of limitations set forth in § 15-1-49, even though the insurer was first notified of the accident approximately 61/2 years after the date of the accident, where the insured was 17 years old when she was injured in the accident, and therefore, pursuant to § 15-1-59, the statute of limitations did not begin to run against her until she reached her 21st birthday. The policy and purpose behind the Uninsured Motorist Act is to provide the same protection to one injured by an uninsured motorist as that individual would have if injured by a financially responsible driver. Thus, since the insured's cause of action against the uninsured motorist was not barred, her claim against the insurer was viable; since uninsured motorist coverage was purchased, the insurer had an obligation to protect the insured as long as the claim against the uninsured motorist was permitted. Lawler v. Government Employees Ins. Co., 569 So. 2d 1151, 1990 Miss. LEXIS 534 (Miss. 1990).

Section 83-11-101(1) requires only that each liability policy provides some uninsured motorist coverage to the insured, but does not require that uninsured motorist coverage be provided on each of several vehicles for which liability coverage is provided under single policy. Pride v. General Agents Ins. Co., 697 F. Supp. 1417, 1988 U.S. Dist. LEXIS 11559 (N.D. Miss. 1988).

Insurer's contesting coverage for noncompliance with written proof of loss provision does not constitute bad faith; mere inquiry or request for information from insurance agent is not equivalent of filing claim; telephone call by relative of insured to insurance agent concerning motorcycle accident of insured with uninsured motorist does not constitute properly filed claim under insured's separate automobile policies, where discussion was limited to insured's motorcycle policy, which had lapsed, and no discussion of separate auto policies and uninsured motorist provisions of those policies were discussed; availability of attorney's fees in insurance claims litigation which do not involve bad faith actions but in which claims were denied through simple negligence or misjudgment of insurer are desirable and would wholly compensate insured who is entitled to proceeds when they become due and payable under policy. Donahoo v. State Farm Mut. Auto. Ins. Co., 684 F. Supp. 911, 1987 U.S. Dist. LEXIS 13475 (N.D. Miss. 1987).

Plaintiff, who was passenger in his employer's truck and who was injured in accident while both he and co-employee uninsured driver were acting within course of their employment, was not entitled to uninsured motorist benefits, despite provision in insurance policy on truck issued to plaintiff's employer that excluded from liability coverage all worker's compensation-covered injuries to employer's employees. Perkins v. Insurance Co. of North America, 799 F.2d 955, 1986 U.S. App. LEXIS 30480 (5th Cir. Miss. 1986).

Automobile insurance policy provision, which excluded from uninsured motorist coverage any vehicle not insured for such coverage under the policy, excluded all uninsured motorist coverage for any vehicle not listed in the policy and not just that uninsured coverage in excess of that required by statute, and the provision was invalid. Employers Mut. Casualty Co. v. Tompkins, 490 So. 2d 897, 1986 Miss. LEXIS 2489 (Miss. 1986).

Under § 83-11-101, uninsured motorist coverage is required to be offered with all bodily injury liability policies and any attempt to contractually limit an insurer's duty of coverage is necessarily confined to the boundaries of the statute and may not be effective to narrow the requirements of that statute; thus where the insured, who was injured while riding as a passenger in her own car, brought suit against her insurance company to recover under her uninsured motorist coverage, and where her policy expressly forbade her to make a claim based on liability of an uninsured operator of her own vehicle, the Supreme Court held would find that, in light of the fact that the driver was an uninsured motorist, it was against public policy of the state to allow the insurance company to exclude the insured from coverage. State Farm Mut. Auto. Ins. Co. v. Nester, 459 So. 2d 787, 1984 Miss. LEXIS 1971 (Miss. 1984), overruled, Burns v. Burns, 518 So. 2d 1205, 1988 Miss. LEXIS 18 (Miss. 1988).

Recovery under uninsured or underinsured motorist liability insurance cannot be limited by an insurer for benefits for which a premium is paid by an insured, notwithstanding clear and unambiguous language of attempted limitation by the insurer. Thus, on a claim involving one of three insured vehicles, aggregation of coverages is permitted on two distinct theories: (1) uninsured motorist coverage contained in one policy of insurance insuring the three vehicles, and for which a separate premium was paid, can be aggregated; (2) while the language of the "limits of liability" clause of the insurance policy is clear and unambiguous as to what is intended, when read together with the declaration sheet it becomes unclear and ambiguous, inasmuch as the declaration sheet seeks to provide separate coverages for uninsured motorists on three vehicular units and charges separate premiums therefor while the "limits of liability" clause seeks to repudiate such coverage; on either theory the limitation fails and is void. Government Employees Ins. Co. v. Brown, 446 So. 2d 1002, 1984 Miss. LEXIS 1598 (Miss. 1984).

Section 83-11-101 does not mandate limits of uninsured motorist coverage equivalent to limits of liability coverage. Johnston v. Safeco Ins. Co., 727 F.2d 548, 1984 U.S. App. LEXIS 24227 (5th Cir. Miss. 1984).

The fact that the advertisement by the State Highway Commission for bids on liability insurance for its motor vehicles and equipment did not mention uninsured motorist coverage did not constitute an implied rejection on such coverage by the Commission. Parker v. Cotton Belt Ins. Co., 314 So. 2d 342, 1975 Miss. LEXIS 1679 (Miss. 1975).

Where an automobile liability insurance policy contained a clause excluding bodily injuries to an insured while occupying or through being struck by a land motor vehicle owned by a named insured or any resident of the same household, if such vehicle was not an owned motor vehicle, and insured's son was clearly within the terms of the exclusionary provision of the policy since he was riding a motorcycle which he owned when he was struck by an uninsured motorist, and his motorcycle was not an "owned motor vehicle" as set out in the declaration of the motor vehicle insured, nevertheless the exclusionary clause of the policy violated the public policy of Mississippi by conflicting with the Mississippi statute requiring all automobile liability insurance policies to contain an uninsured motorist provision. Lowery v. State Farm Mut. Auto Ins. Co., 285 So. 2d 767, 1973 Miss. LEXIS 1303 (Miss. 1973), overruled in part, Wickline v. United States Fidelity & Guaranty Co., 1988 Miss. LEXIS 247 (Miss. Apr. 6, 1988).

Upon an insured establishing the legal liability of the uninsured motorist, an insurance company would be required to pay such judgment within the applicable limits of the policy. Logan v. Aetna Casualty & Surety Co., 309 F. Supp. 402, 1970 U.S. Dist. LEXIS 12928 (S.D. Miss. 1970).

The omnibus clause in an automobile liability insurance policy which allows the insured to include others as insureds under the policy merely by granting permission to use the vehicle should be construed in the light of the manifest public policy of this state as indicated by the Motor Vehicle Safety Responsibility Law and the Uninsured Motor Vehicle Law, both of which clearly indicate the legislative policy of protecting the public and providing insurance coverage where persons are injured on the highways of the state. Travelers Indem. Co. v. Watkins, 209 So. 2d 630, 1968 Miss. LEXIS 1464 (Miss. 1968).

2. Construction.

Circuit court properly granted an insurer's motion to dismiss an injured employee's action to recover damages from her employer under the uninsured motorist statute because an employee was not "legally entitled to recover" from an employer due to the exclusivity of the workers' compensation remedy, and the Supreme Court of Mississippi had already addressed and rejected the public policy arguments that the employee advanced. Bufkin v. Geico Ins. Agency, Inc., 337 So. 3d 1049, 2022 Miss. LEXIS 127 (Miss. 2022).

Provisions of Miss. Code Ann. § 83-11-101(2) are to be liberally construed to achieve its purpose. Jones v. Southern United Fire Ins., 935 So. 2d 1127, 2006 Miss. App. LEXIS 565 (Miss. Ct. App. 2006).

In the context of the application of Miss. Code Ann. § 83-11-101(2), no employee needs to waive or limit uninsured motorist coverage if the company itself does so in writing, either through a document that it signs or one signed by a properly authorized agent. Trotter v. Fed. Ins. Co., 865 So. 2d 411, 2004 Miss. App. LEXIS 107 (Miss. Ct. App. 2004).

When an insured named in the policy puts in writing the limits on uninsured motorist coverage that it wants, this satisfies Miss. Code Ann. § 83-11-101(2) (Rev. 1999). In such case, limits on uninsured motorist coverage solely to vehicles that the employer owns is properly requested in writing, and is therefore effective. Trotter v. Fed. Ins. Co., 865 So. 2d 411, 2004 Miss. App. LEXIS 107 (Miss. Ct. App. 2004).

As under Miss. Code Ann. § 71-3-9, the insured was not "legally entitled to recover" any damages from his employer or the co-employee who injured him in an auto accident, he was not entitled under Miss. Code Ann. § 83-11-101(1) to recover uninsured motorist benefits from his private insurer for this accident. Wachtler v. State Farm Mut. Auto. Ins. Co., 835 So. 2d 23, 2003 Miss. LEXIS 14 (Miss. 2003).

Purpose of the Uninsured Motorist Act and Uninsured Motorist coverage was to insure that injured parties could receive all sums they are legally entitled to recover as damages for bodily injury. McDaniel v. Shaklee U.S., Inc., 807 So. 2d 393, 2001 Miss. LEXIS 287 (Miss. 2001), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Courts should liberally construe provisions of Mississippi's Uninsured Motorist Act (UM Act) to effectuate its remedial and humanitarian purposes. Boatner v. Atlanta Specialty Ins. Co., 115 F.3d 1248, 1997 U.S. App. LEXIS 22634 (5th Cir. Miss. 1997).

Under Mississippi's Uninsured Motorist Act (UM Act), uninsured motorist provisions within automobile insurance policies must be interpreted from standpoint of injured insured. Boatner v. Atlanta Specialty Ins. Co., 115 F.3d 1248, 1997 U.S. App. LEXIS 22634 (5th Cir. Miss. 1997).

Although Mississippi Supreme Court has not always closed its judicial eye to insurance law of other jurisdictions, court has more recently suggested that courts interpreting Mississippi uninsured motorist law should be guided by terms of Mississippi's Uninsured Motorist Act (UM Act), not jurisprudence of foreign jurisdictions. Boatner v. Atlanta Specialty Ins. Co., 115 F.3d 1248, 1997 U.S. App. LEXIS 22634 (5th Cir. Miss. 1997).

Although court should avoid exceptions or exemptions from coverage under Mississippi's Uninsured Motorist Act (UM Act), court cannot rewrite Act to include situations not expressly provided for or contemplated under guise of liberally construing Act in order to accomplish its designed purpose. Boatner v. Atlanta Specialty Ins. Co., 115 F.3d 1248, 1997 U.S. App. LEXIS 22634 (5th Cir. Miss. 1997).

Certificate of self-insurance is not commercial insurance policy subject to provisions of Uninsured Motorist Act. McCoy v. South Cent. Bell Tel. Co., 688 So. 2d 214, 1996 Miss. LEXIS 634 (Miss. 1996).

Where uninsured motorist benefits were written into an assigned risk policy through operation of law, the amount of coverage was the statutory minimum, rather than the amount contracted in a previously cancelled policy, where there was no evidence that the parties intended to impute the uninsured motorist limits from the cancelled policy into the assigned risk policy. Harris v. Magee, 573 So. 2d 646, 1990 Miss. LEXIS 900 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Statutory definition of underinsured vehicle should be construed literally with respect to limits of coverage. Herrod v. National Indem. Co., 643 F. Supp. 956, 1986 U.S. Dist. LEXIS 20642 (N.D. Miss. 1986).

3. Provisions included by law in insurance policies.

If provisions of Mississippi's Uninsured Motorist Act (UM Act) provide broader protection than uninsured motorist policy, then terms of Act become part of policy, providing insured statutory level of monetary protection. Boatner v. Atlanta Specialty Ins. Co., 115 F.3d 1248, 1997 U.S. App. LEXIS 22634 (5th Cir. Miss. 1997).

All automobile policies are required to include uninsured motorist coverage unless specifically waived; this includes coverage for corporations, as distinct from coverage from individuals, which have paid premiums to provide employees of such corporations with uninsured motorist coverage. Pemberton v. State Farm Mut. Auto. Ins. Co., 803 F. Supp. 1187, 1992 U.S. Dist. LEXIS 15727 (S.D. Miss. 1992).

The uninsured motorist provision was included by law in a policy of insurance which became effective after the effective date of this chapter. United States Fidelity & Guaranty Co. v. Gough, 289 So. 2d 925, 1974 Miss. LEXIS 1695 (Miss. 1974).

4. Oral promise to bind uninsured motorist policy.

In an action by an insured against his insurer alleging that the insurer had negligently failed to provide the insured with uninsured motorist coverage prior to his automobile accident with an uninsured motorist, the insurer's oral promise to provide uninsured motorist coverage was binding, even in the absence of a written request for that coverage by the insured, and even though the insured had previously rejected such coverage; summary judgment for the insurer was improper where there existed a genuine issue of material fact as to whether the insurer orally promised to bind the uninsured motorist policy; the doctrine of res ipsa loquitur could be used to infer of that the uninsured motorist was negligent. Stringer v. Bufkin, 465 So. 2d 331, 1985 Miss. LEXIS 1963 (Miss. 1985).

Oral promise by insurance agent to provide uninsured motorist coverage is binding upon insurance company represented by agent even in absence of written request for coverage by insured who has previously rejected it. Stringer v. Bufkin, 465 So. 2d 331, 1985 Miss. LEXIS 1963 (Miss. 1985).

5. Who is "uninsured" or "underinsured."

Where a passenger was injured, the

passenger did not demonstrate that the insured driver was an underinsured motorist under the standard set forth by the Mississippi Supreme Court, which required a comparison of the tortfeasor's liability coverage and the personal coverage carried by, or available to the injured party, nor did the passenger demonstrated good reason to abandon that standard; thus, summary judgment for the insurer on the passenger's claim for underinsured motorist benefits was proper. Byrd v. Hutchinson, 876 So. 2d 1092, 2004 Miss. App. LEXIS 612 (Miss. Ct. App. 2004).

The statutory definition of an underinsured motorist contained in § 83-11-103(c)(iii) cannot be read in isolation, but must be interpreted in light of other pertinent provisions within the uninsured motorist scheme, such as § 83-11-101(1). Since § 83-11-101(1) prohibits issuance of uninsured coverage in an amount greater than the liability coverage provided for in the policy, in one-vehicle accidents, unless the injured person, as referred to in § 83-11-103(c)(iii), is allowed to stack his or her uninsured motorist coverage with the coverage on the insured motor vehicle, the insured motor vehicle would never be underinsured because the uninsured motorist limits on such a vehicle would never exceed its liability limits. Thiac v. State Farm Mut. Auto. Ins. Co., 569 So. 2d 1217, 1990 Miss. LEXIS 670 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

A host vehicle, in which a guest passenger was riding when the vehicle left the road and hit a tree, was not an uninsured vehicle for the purposes of § 83-11-103(c)(iii) where the guest passenger had no uninsured coverage of her own and the host vehicle provided liability coverage of $25,000, so that the liability coverage was not less than the guest's uninsured motorist coverage. Although a guest passenger is permitted to stack his or her own uninsured motorist coverage with the uninsured motorist coverage on the host vehicle for the purpose of qualifying the host vehicle as underinsured, the guest passenger was not allowed to stack the host vehicle's policy to qualify the vehicle as underinsured since the guest had no insurance of her own. To allow her to stack the host vehicle's policy for the purposes of determining whether the vehicle was underinsured would be contrary to the legislative purpose in adopting the underinsured motor vehicle concept as part of Mississippi's statutory scheme; the guest passenger could have contracted with her carrier for excess coverage beyond the statutory minimum, thereby rendering the host vehicle underinsured. For the purpose of establishing whether an insured host vehicle is, in fact, underinsured, the court looks no further than the guest passenger's own coverage and the coverage on the host vehicle. Thiac v. State Farm Mut. Auto. Ins. Co., 569 So. 2d 1217, 1990 Miss. LEXIS 670 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

A tortfeasor did not become an "uninsured motorist" with respect to an injured party such that the injured party's uninsured motorist coverage would apply, where multiple claimants under the tortfeasor's liability policy, other than the injured party, had totally exhausted the available proceeds, but the limit of liability provided by the tortfeasor's insurer was not less than the limit provided by the injured party's own uninsured motorist coverage. Cossitt v. Federated Guaranty Mut. Ins. Co., 541 So. 2d 436, 1989 Miss. LEXIS 138 (Miss. 1989).

Since combined liability limit of $25,000 under tortfeasor's policy exceeds $20,000 bodily injury limit under plaintiff's uninsured motorist coverage, tortfeasor was not underinsured motorist, as defined in Mississippi Uninsured Motorist Act and plaintiff's policy; thus, neither plaintiff policyholder nor other plaintiffs are eligible for underinsured motorist coverage, notwithstanding that each plaintiff received proceeds under tortfeasor's liability policy in sum less than statutory minimum of $10,000 per person (§ 63-15-43(2)(b)). Herrod v. National Indem. Co., 643 F. Supp. 956, 1986 U.S. Dist. LEXIS 20642 (N.D. Miss. 1986).

6. Beneficiaries; assignment of benefits.

Benefits payable under uninsured motorist insurance policy due to injuries resulting in death of insured need not be paid to persons designated under wrongful death statute (§ 11-7-13), but may be paid to surviving spouse in accordance with "facility of payment" clause. Overstreet v. Allstate Ins. Co., 474 So. 2d 572, 1985 Miss. LEXIS 2195 (Miss. 1985).

Named insured has no authority to assign to medical provider uninsured motorist benefits under liability insurance policy for injuries received by minor son of insured. McCoy on behalf of McCoy v. Preferred Risk Ins. Co., 471 So. 2d 396, 1985 Miss. LEXIS 2126 (Miss. 1985).

7. Recovery and elements of damages.

If insurance agent breaches duty to explain uninsured motorist (UM) coverage to insured, damages should not be awarded in amount less than statutory minimum for UM coverage of $10,000, nor in amount more than limits of particular policy in question. Aetna Casualty & Sur. Co. v. Berry, 669 So. 2d 56, 1996 Miss. LEXIS 20 (Miss. 1996), overruled in part, Owens v. Miss. Farm Bureau Cas. Ins. Co., 910 So. 2d 1065, 2005 Miss. LEXIS 562 (Miss. 2005).

In an action to recover under the uninsured motorist provisions of a decedent's policy brought by the decedent's 2 personal representatives, each representative was not entitled to recover "per person" limits under the policy since the representatives' status as insureds was due to their status as wrongful death beneficiaries under § 11-7-13, which provides a derivative action by the beneficiaries. Thus, the representatives' total recovery was limited to that amount to which the decedent would have been entitled, to be shared equally between them. Wickline v. United States Fidelity & Guaranty Co., 530 So. 2d 708, 1988 Miss. LEXIS 448 (Miss. 1988), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Jury's award of $500 in actual damages to insured motorcyclist who was injured in rear-end collision with uninsured automobile operated by defendant meant that its contractual damages award to the insured of $50,000 against his insurer was excessive by $49,500, in view of policy provision limiting insured's recovery against insurer to amount legally recoverable from owner or operator of uninsured vehicle. Moreover, an award against an insurer of $50,000 which carried with it subrogation rights of $500 was anomalous. Thus, contractual damage award against the insurer was reduced to Employers Mut. Casualty Co. v. Tompkins, 490 So. 2d 897, 1986 Miss. LEXIS 2489 (Miss. 1986).

This section does not limit uninsured motorist coverage to damages for bodily injury or death, to the exclusion of damages for loss of income; thus, the trial court in an automobile accident case erred in striking the jury's award of $2250 in damages for plaintiff insured's loss of income. Black v. Fidelity & Guaranty Ins. Underwriters, Inc., 582 F.2d 984, 1978 U.S. App. LEXIS 8132 (5th Cir. Miss. 1978).

8. —Aggregating or "stacking" of claims.

Summary judgment was properly granted to two insurers because an employee's uninsured motorist coverage was insufficient to entitle him to uninsured motorist benefits; under Miss. Code Ann. §§ 83-11-101, 83-11-103, the Class II insured had no personal uninsured motorist benefits to stack with a business policy, and an umbrella policy did not count. The following cases were overruled: Glennon v. State Farm Mut. Auto. Ins. Co.; McDaniel v. Shaklee United States, Inc.; State Farm Mut. Auto. Ins. Co v. Davis; Thiac v. State Farm Mut. Auto. Ins. Co.; Harris v. Magee; Cossitt v. Nationwide Mut. Ins. Co.; Wickline v. United States Fid. & Guar. Co.; Brown v. Md. Cas. Co. Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Statutes such as the Mississippi Uninsured Motorist Act (UM) have to be liberally construed, due in part to their remedial nature; the concept of stacking, or aggregating policies, as a viable method of ensuring complete recovery where the limits of bodily injury liability of one policy were insufficient to cover the costs of the injured party, has begun to gain favor in Mississippi. McDaniel v. Shaklee U.S., Inc., 807 So. 2d 393, 2001 Miss. LEXIS 287 (Miss. 2001), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Nothing in uninsured motorist (UM) statute precludes insurer and insured from contractually agreeing to aggregate amount of UM coverage on multiple vehicles even though aggregation exceeds insured's liability coverage limits. United States Fid. & Guar. Co. v. Ferguson, 698 So. 2d 77, 1997 Miss. LEXIS 304 (Miss. 1997).

Uninsured motorist (UM) statute, by authorizing insured to demand up to amount of his liability limits in UM coverage, did not bar aggregation of UM coverage on three vehicles under insured's policy, such that insured was entitled to $75,000 in coverage, representing $25,000 limits on each vehicle, even though she carried only $25,000 in liability coverage. United States Fid. & Guar. Co. v. Ferguson, 698 So. 2d 77, 1997 Miss. LEXIS 304 (Miss. 1997).

Under Mississippi law, stacking of uninsured motorist (UM) coverage is not mandated by statute, but rather is required in cases where policy is ambiguous concerning whether more than one premium is being charged for more than one UM coverage. Thomas v. Allstate Ins. Co., 969 F. Supp. 1352, 1996 U.S. Dist. LEXIS 21185 (S.D. Miss. 1996), aff'd, 114 F.3d 483, 1997 U.S. App. LEXIS 12808 (5th Cir. Miss. 1997).

Under Mississippi law, where insured's three vehicles were covered under same automobile policy, her successors could not stack more than two $10,000 uninsured motorist (UM) coverage limits after insured died in accident involving uninsured motorist, even though insured paid separate premium for liability coverage on each of her three vehicles, where policy contained clear and unambiguous anti-stacking provision and insurer charged this insured and all its insureds only one extra premium for multi-vehicle UM coverage no matter how many vehicles insured owned. Thomas v. Allstate Ins. Co., 969 F. Supp. 1352, 1996 U.S. Dist. LEXIS 21185 (S.D. Miss. 1996), aff'd, 114 F.3d 483, 1997 U.S. App. LEXIS 12808 (5th Cir. Miss. 1997).

An insured, who was involved in a motor vehicle accident while driving a vehicle owned by him and insured under a commercial automobile policy issued to his commercial farming operation, was entitled to recover the full $200,000 of underinsured motorist (UM) coverage under his personal automobile policy where he had purchased $100,000 of UM coverage on each of the 2 vehicles under his personal automobile policy, and had a liability limit of $500,000; under the circumstances, the statutory minimum coverage was $200,000 [§ 83-11-101(1)], and thus there was no excess UM coverage which could be subject to the clause in the policy limiting the insurer's stacking exposure. Land v. United States Fidelity & Guar. Co., 861 F. Supp. 544, 1994 U.S. Dist. LEXIS 12105 (S.D. Miss. 1994), rev'd in part, 78 F.3d 187, 1996 U.S. App. LEXIS 5629 (5th Cir. Miss. 1996).

Guest passengers who were in an insured vehicle at the time of a collision with an uninsured motorist were not entitled to stack 5 uninsured motorist coverages sold by the insurer to the owner of the vehicle in which they were passengers where they were Class 2 "insureds" under the policy, and were therefore limited to the uninsured motorist coverage on the vehicle in which they were passengers. Duncan v. Duncan, 634 So. 2d 108, 1994 Miss. LEXIS 130 (Miss. 1994).

Guest passenger who is injured while occupant of an underinsured motor vehicle may not recover from uninsured motorist insurance carried by named insured on another vehicle not involved in accident in question, where insurance on such other vehicle is provided under separate insurance policy; such guest passenger is not "insured" and is not entitled to stack coverage under policy. Thomas v. State Farm Mut. Auto. Ins. Co., 796 F. Supp. 231, 1992 U.S. Dist. LEXIS 9432 (S.D. Miss. 1992).

Guest passenger who was injured while an occupant of underinsured motor vehicle may not recover from uninsured motorist insurance carried by named insured on another vehicle not involved in accident, where insurance on such other vehicle is provided under separate insurance policy, as to which injured person is not an insured. Thomas v. State Farm Mut. Auto. Ins. Co., 796 F. Supp. 231, 1992 U.S. Dist. LEXIS 9432 (S.D. Miss. 1992).

In a wrongful death action brought by the parents of a passenger who was killed in a motor vehicle accident, the parents were entitled to receive only the uninsured motor vehicle (UM) coverage provided by their own policies and the policy covering the accident vehicle, and were not entitled to the UM coverage provided by 2 other insurance policies issued to the owners of the accident vehicle which covered 2 other automobiles; the parents were entitled to stack the UM coverage provided by the policies in which the passenger met the definition of an "insured" either under the terms of the policy and/or the UM statute, and the passenger was an "insured" only under the policy covering the accident vehicle since she was a guest passenger in that vehicle but was not a guest passenger in either of the other 2 vehicles covered under the other policies issued to the owners. State Farm Mut. Auto. Ins. Co. v. Davis, 613 So. 2d 1179, 1992 Miss. LEXIS 829 (Miss. 1992), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

An insured was not entitled to stack uninsured motorist coverages where the policies providing the coverages prohibited stacking of coverages in excess of the statutory minimum. Casualty Reciprocal Exch. v. Federal Ins. Co., 608 So. 2d 1258 (Miss. 1992).

A trial court properly allowed a second class permissive user to stack insured motorist benefits under his employer's commercial fleet policy. Mississippi's statutory scheme does not distinguish a "commercial fleet policy" from any other type of automobile insurance policy, nor is it defined therein, and therefore there is no statutory basis for distinguishing a commercial fleet policy. Harris v. Magee, 573 So. 2d 646, 1990 Miss. LEXIS 900 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

A Class II insured who was using his employer's insured vehicle at the time of the accident was entitled to stack uninsured motorist benefits under his employer's commercial fleet policy. There is no basis for distinguishing a "commercial fleet policy" from any other type of auto insurance policy. Uninsured motorist coverage is designed to provide innocent injured motorists a means to recover all sums to which they are entitled from an uninsured motorist. The statute is to be liberally construed so as to achieve compensation. Uninsured motorist coverage is available to an injured insured until all sums which he or she is entitled to recover from the uninsured motorist have been recovered. Section 83-11-103 specifically refers to use of a "motor vehicle," which indicates that stacking is necessarily limited to those "motor vehicles" listed in the schedule of covered vehicles. Harris v. Magee, 573 So. 2d 646, 1990 Miss. LEXIS 900 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Persons travelling in a church-owned bus on a church outing were entitled to stack the coverage under 3 uninsured motorist policies held by the church on the 3 buses owned by it; the policy was not considered to be a fleet policy. Cossitt v. Nationwide Mut. Ins. Co., 551 So. 2d 879, 1989 Miss. LEXIS 318 (Miss. 1989), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

A "Class 2 Occupancy Insured" (a person who uses, with the consent of the named insured, the motor vehicle to which the insurance policy applies) is entitled to stack the coverages held by the named insured under his or her uninsured motorist policy. Brown v. Maryland Casualty Co., 521 So. 2d 854, 1987 Miss. LEXIS 2618 (Miss. 1987), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Although he was "insured" within meaning of uninsured motorist policy, husband of woman injured in accident could not collect for loss of consortium as claim was subject to per person limitation applicable to wife's claim; husband was not entitled to stack uninsured motorist coverage of two separate policies. Reid v. State Farm Mut. Auto. Ins. Co., 784 F.2d 577, 1986 U.S. App. LEXIS 23221 (5th Cir. Miss. 1986).

Although insurer's maximum liability is aggregate of all uninsured motorist policies under which injured person is covered, "per person" limitations in policies refer to injured person only, not to persons who may make claim under policy. State Farm Mut. Auto. Ins. Co. v. Eubanks, 620 F. Supp. 17, 1985 U.S. Dist. LEXIS 17700 (N.D. Miss. 1985), aff'd, 785 F.2d 1346, 1986 U.S. App. LEXIS 23704 (5th Cir. Miss. 1986).

Motorist who has uninsured motorist benefits under 2 insurance policies covering 2 vehicles who is severely injured when hit by uninsured motorist while driving one of insured vehicles is limited to recovery of $10,000 where each policy provides for uninsured motorist coverage in that amount. State Farm Mut. Auto. Ins. Co. v. Acosta, 479 So. 2d 1089, 1985 Miss. LEXIS 2278 (Miss. 1985).

The $10,000 coverage afforded by the uninsured motorist endorsements to three separate liability policies issued by the same insurer to the same insured could be aggregated to cover damages for bodily injuries suffered by the minor son of the insured as a proximate result of the negligence of an uninsured motorist. Southern Farm Bureau Casualty Ins. Co. v. Roberts, 323 So. 2d 536, 1975 Miss. LEXIS 1564 (Miss. 1975).

9. —Exclusion of or offset against benefits payable under other provisions or policies.

Vehicle insurance provision stating that no insured for whom medical expenses were payable could recover more than once for the same medical expense was not an attempt to reduce the minimum amount of uninsured motor vehicle (UM) coverage required under Mississippi law, and thus the provision prevented an insured from recovering double medical expenses under the UM and medical payment coverage provisions of her policy. Welborn v. State Farm Mut. Auto. Ins. Co., 2007 U.S. App. LEXIS 4871 (5th Cir. Miss. Feb. 6, 2007).

Grant of summary judgment in favor of the insurer in the operator's action concerning an offset against the insurer's uninsured motorist coverage limits was proper pursuant to the Uninsured Motorist Act (Act), Miss. Code Ann. § 83-11-101 et seq., where the operator received $ 600,000 from another insurer and had therefore already received far more than the minimum $ 10,000 contracted for and required by the Act. Additionally, the offset clause did not provide an offset for sums paid to parties other than the operator. Jeffcoat v. Am. Nat'l Prop. & Cas. Co., 919 So. 2d 982, 2005 Miss. App. LEXIS 421 (Miss. Ct. App. 2005).

Where an injured guest-passenger's uninsured or underinsured motorist (UM) policy only allowed the insurer to offset amounts actually paid by it, the host driver's UM insurer was entitled to take its contractual liability insurance offset before the injured passenger's UM insurer, and the passenger's insurer was not entitled to pro-ration of the offset provision of the driver's policy. Dixie Ins. Co. v. State Farm Mut. Auto. Ins. Co., 614 So. 2d 918, 1992 Miss. LEXIS 823 (Miss. 1992).

A workers' compensation carrier, which was also the uninsured motorist carrier, was not entitled to a credit on behalf of a deceased employee, where the employee's beneficiary had failed to recover anything from the party responsible for the employee's death. Harris v. Magee, 573 So. 2d 646, 1990 Miss. LEXIS 900 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Provision in automobile liability insurance policy providing that amounts payable under uninsured motorist insurance shall be reduced by amount paid and present value of all amounts payable under any workmen's compensation law, disability benefits law or similar law cannot reduce uninsured motorist benefits below statutory minimum, however, such provision can be applied to supplemental benefits, as Miss. Code Annotated § 83-11-111 provides that any coverage in excess of coverage required by law shall not be subject to provisions of law, such that supplemental benefits may be reduced by amounts received under worker's compensation law. Porter v. Shelter Gen. Ins. Co., 678 F. Supp. 151, 1988 U.S. Dist. LEXIS 1207 (S.D. Miss. 1988).

Although insurer may not reduce uninsured motorist benefit below statutory minimum because of workers' compensation benefits, provision in insurance policy which allows insurer to reduce all of uninsured motorist benefits in excess of statutory minimum for any amounts received as workers' compensation is permissible. Porter v. Shelter Gen. Ins. Co., 678 F. Supp. 151, 1988 U.S. Dist. LEXIS 1207 (S.D. Miss. 1988).

Under Mississippi law, parties are free to contract for supplemental benefits as they see fit so long as uninsured motorist benefits do not exceed liability benefits and insurance policy provision for reduction of supplemental uninsured motorist benefits because of workers' compensation received by beneficiary is enforceable with regard to those benefits, although benefits may not be reduced below minimum required by statute. Section 83-11-111 provides that any coverage in excess of coverage required by that article "shall not be subject to provisions of this article" except as provided. Porter v. Shelter Gen. Ins. Co., 678 F. Supp. 151, 1988 U.S. Dist. LEXIS 1207 (S.D. Miss. 1988).

Clause in uninsured motorist provision of automobile insurance policy providing that insured may not recover for expenses for medical services payable under separate provision of policy does not reduce policy's uninsured motorist limit below statutory minimum, but merely provides that insured would not be paid for medical expenses twice, once under medical payment coverage and again under uninsured motorist provision. Tucker v. Aetna Casualty & Surety Co., 801 F.2d 728, 1986 U.S. App. LEXIS 31464 (5th Cir. Miss. 1986).

Although automobile of tortfeasor who carries liability insurance in amount less than amount of coverage available to injured person under that person's uninsured motorist provisions of injured person's policies is "uninsured motor vehicle" by statutory definition (§ 83-11-103), uninsured motorist coverage may be reduced by offset for sums paid by another company on behalf of under-insured driver where uninsured motorist provision so provides. State Farm Mut. Auto. Ins. Co. v. Eubanks, 620 F. Supp. 17, 1985 U.S. Dist. LEXIS 17700 (N.D. Miss. 1985), aff'd, 785 F.2d 1346, 1986 U.S. App. LEXIS 23704 (5th Cir. Miss. 1986).

In creating underinsured motorist coverage by amendment of § 83-11-103, legislature did not intend to abrogate rights of underinsured motorist carriers to subrogation as provided in § 83-11-107 and, therefore, underinsured motorist carrier may be allowed offset for payments by underinsured tortfeasor's liability carrier. State Farm Mut. Auto. Ins. Co. v. Kuehling, 475 So. 2d 1159, 1985 Miss. LEXIS 2235 (Miss. 1985), limited, Fidelity & Guar. Underwriters v. Earnest, 699 So. 2d 585, 1997 Miss. LEXIS 384 (Miss. 1997).

An insurance company may not validly offset payments made pursuant to uninsured motorist coverage against payments due under the bodily injury liability provision of the same policy, and a policy clause permitting such offset was void as against public policy. Missouri General Ins. Co. v. Youngblood, 515 F.2d 1254, 1975 U.S. App. LEXIS 13672 (5th Cir. Miss. 1975).

Where a passenger on a motorcycle uninsured as to her, which was involved in an intersection collision with an automobile, the fact that the injured plaintiff recovered damages under the bodily injury coverage of the automobile driver's liability policy, did not extinguish the uninsured motorist coverage provided by both the automobile liability policy of the passenger's husband, in whose household she lived, and the policy covering the motorcycle involved in the accident. Harthcock v. State Farm Mut. Auto. Ins. Co., 248 So. 2d 456, 1971 Miss. LEXIS 1473 (Miss. 1971).

10. —Punitive damages.

Uninsured motorist coverage provision of automobile liability policy need not cover punitive damages that insured would be legally entitled to collect from uninsured motorist; nor does uninsured motorist endorsement providing that insurer will pay damages for bodily injury and property damage cover punitive damages. State Farm Mut. Auto. Ins. Co. v. Daughdrill, 474 So. 2d 1048, 1985 Miss. LEXIS 2169 (Miss. 1985).

The federal court of appeals would certify to the Mississippi Supreme Court the question whether the uninsured motorist coverage provision of an automobile liability policy issued to a person resident in Mississippi covers punitive damages that the insured would be entitled to collect from the uninsured motorist, where neither the Mississippi Supreme Court nor any Mississippi appellate court had decided the significant question. State Farm Mut. Auto. Ins. Co. v. Daughdrill, 695 F.2d 141, 1983 U.S. App. LEXIS 27667 (5th Cir. Miss. 1983).

11. Applicability to particular vehicles.

Where an employee was injured in a car accident with an uninsured motorist while in the scope of employment and using the employee's own car, the limitation on uninsured motorist coverage solely to vehicles owned by the employer was effective, having been requested in writing, and summary judgment on the employee's bad faith claim was properly granted to the employer's insurer . Trotter v. Fed. Ins. Co., 865 So. 2d 411, 2004 Miss. App. LEXIS 107 (Miss. Ct. App. 2004).

Farm tractor is not vehicle designed for use mainly on public roads and is instead vehicle designed mainly for use off public roads. Wilcher v. Michigan Mut. Ins. Co., 691 F. Supp. 1019, 1988 U.S. Dist. LEXIS 9020 (S.D. Miss. 1988).

12. When cause of action accrues.

A father's cause of action against his insurance company under the uninsured motorist provisions of his policy, for injuries to his son, an occupant in a one-car accident, did not accrue until the appellate court issued its opinion affirming the trial court's judgment in a prior action by the father against the driver that the driver of the vehicle was not insured, and the action thus was not barred by the six-year limitation period. Vaughn v. State Farm Mut. Auto. Ins. Co., 445 So. 2d 224, 1984 Miss. LEXIS 1591 (Miss. 1984).

13. Which state's law applies.

In a dispute over the payment of uninsured motorist benefits, a trial court properly applied the center of gravity test in determining that Tennessee law applied because the contract was made in Tennessee, negotiations took place there, and an insured resided there, despite the fact that an accident took place in Mississippi. Owens v. Miss. Farm Bureau Cas. Ins. Co., 910 So. 2d 1065, 2005 Miss. LEXIS 562 (Miss. 2005).

As predicted by Court of Appeals, Mississippi legislature did not intend that Mississippi's Uninsured Motorist Act (UM Act) would provide Mississippians worldwide uninsured motorist (UM) coverage; thus, UM policy that limited recovery to losses occurring within United States (and its territories and possessions), Canada, and Puerto Rico, did not violate Mississippi public policy. Boatner v. Atlanta Specialty Ins. Co., 115 F.3d 1248, 1997 U.S. App. LEXIS 22634 (5th Cir. Miss. 1997).

As predicted by Court of Appeals, Mississippi's Uninsured Motorist Act (UM Act) is subject to same territorial restrictions found in Mississippi Safety Responsibility Act. Boatner v. Atlanta Specialty Ins. Co., 115 F.3d 1248, 1997 U.S. App. LEXIS 22634 (5th Cir. Miss. 1997).

There is no public policy in Mississippi that would preclude enforcement of exclusionary clause of uninsured motorist provision of insurance contract which is made and entered into in Nebraska between Nebraska insured and nationwide insurer based in San Antonio, Texas, particularly where party seeking to recover under insurance contract is not resident of Mississippi at controlling time. Boardman v. United Services Auto. Asso., 470 So. 2d 1024, 1985 Miss. LEXIS 2095 (Miss. 1985).

Vehicle ownership question in action brought in Mississippi under uninsured motorist provision of insurance contract will be determined in accordance with Mississippi law, even though other issues are determined under law of another state, where owning of vehicle appears to have occurred exclusively in Mississippi. Boardman v. United Services Auto. Asso., 470 So. 2d 1024, 1985 Miss. LEXIS 2095 (Miss. 1985).

In construing automobile insurance contract containing uninsured motorist provision, Mississippi court will deem Nebraska to be state with most significant contact with insurance policy for choice of law purposes where contract is made and entered in state of Nebraska, insured persons under contract are residents of Nebraska, principal location of risks insured against is in Nebraska, and Mississippi's contact with contract and parties are fortuitous, arising from fact that son of insured has taken summer job in Mississippi. Boardman v. United Services Auto. Asso., 470 So. 2d 1024, 1985 Miss. LEXIS 2095 (Miss. 1985).

14. Prerequisites to bringing suit against insurer.

Summary judgment was properly awarded to an insurance agency and an insurer in an insured's action alleging that she was wrongfully denied uninsured motorist coverage where the insured failed to meet the requirements of requesting uninsured motorist coverage for a renewal policy in writing under Miss. Code Ann. § 83-11-101(2). Jones v. Southern United Fire Ins., 935 So. 2d 1127, 2006 Miss. App. LEXIS 565 (Miss. Ct. App. 2006).

Mississippi Supreme Court rejects and overrules the implication in Aetna Casualty & Surety Co. v. Berry, 669 So. 2d 56 (Miss. 1996), that an insurance agent has the absolute, court-created duty to explain an insured's right to purchase additional uninsured motorist coverage, over and above the amount of coverage required by Miss. Code Ann. § 83-11-101. Owens v. Miss. Farm Bureau Cas. Ins. Co., 910 So. 2d 1065, 2005 Miss. LEXIS 562 (Miss. 2005).

Language in the uninsured motorist statute, Miss. Code Ann. § 83-11-101, as well as the insured's UM policy, required that the insured be legally entitled to recover from the owner or operator of the uninsured vehicle; since that insured could not bring a legal action against the co-employee at the time of the accident, he was not entitled to recover UM benefits from his insurer. Steen v. Metro. Prop. & Cas. Ins. Co., 858 So. 2d 186, 2003 Miss. App. LEXIS 991 (Miss. Ct. App. 2003).

In respect to third party claim brought by uninsured motorist insurer against agent for allegedly uninsured motorist, claiming negligence by agent in failing to provide liability coverage which would have offset amounts uninsured carrier was required to pay arising out of accident, there was no controversy between uninsured motorist carrier and agent, as required in order to sustain declaratory judgment action to establish negligence of agent. Byrd v. Principal Casualty Ins. Co., 781 F. Supp. 1177, 1991 U.S. Dist. LEXIS 19335 (S.D. Miss. 1991).

In an action against an insurer to collect under an uninsured motorist clause, the burden rested upon the plaintiff to prove that the other driver had been an uninsured motorist, that the plaintiff was a member of the named insured's household and was driving her car with the named insured's consent, that while driving the car she was involved in a collision as the proximate result of negligence on the other driver's part, and that she sustained an injury as to the result. State Farm Fire & Casualty Co. v. Wightwick, 320 So. 2d 373, 1975 Miss. LEXIS 1490 (Miss. 1975).

It is not necessary to sue first the faulting motorist in order to establish liability under the uninsured motorist clause in a policy, but suit may be brought directly against the insurance company under its insurance contract in the first instance. Rampy v. State Farm Mut. Auto. Ins. Co., 278 So. 2d 428, 1973 Miss. LEXIS 1442 (Miss. 1973).

An insured, under uninsured motorist coverage, may bring a direct action against the insurer, and need not first establish the liability of the uninsured motorist in a prior suit. Harthcock v. State Farm Mut. Auto. Ins. Co., 248 So. 2d 456, 1971 Miss. LEXIS 1473 (Miss. 1971).

It was the intent of the legislature that the legal liability of a known uninsured motorist to the insured should be ascertained in an appropriate forum before bringing of a suit against the insurance company under such coverage, and this conclusion works no great hardship on the insured because, once a judgment has been obtained against the uninsured motorist, it would only be necessary to show the existence of coverage by the insurance company to entitle the insured to a judgment against the company. Logan v. Aetna Casualty & Surety Co., 309 F. Supp. 402, 1970 U.S. Dist. LEXIS 12928 (S.D. Miss. 1970).

15. Waiver of uninsured motorist coverage.

Fact issues as to whether an insurance agent explained the costs and benefits of uninsured motorist (UM) coverage and whether the insureds gave a knowing and intelligent waiver of UM coverage precluded summary judgment on a UM claim where the insureds testified they did not read the provision before signing a waiver and that the agent did not explain the waiver to them. Honeycutt v. Coleman, 120 So. 3d 358, 2013 Miss. LEXIS 315 (Miss. 2013).

Any waiver of uninsured motorist (UM) coverage must be made knowingly, intelligently, and in writing, with the insurer bearing the burden of proof, which may be met by establishing that the insurer provided an explanation, appropriate to the client, of UM coverage or that the client was fully knowledgeable through other sources of the purposes and benefits of UM coverage; any document signed by the client that states that an explanation was given to the client may be considered, but is not dispositive. Whether a client made a knowing and intelligent waiver of UM coverage is a question of fact for the fact-finder. Honeycutt v. Coleman, 120 So. 3d 358, 2013 Miss. LEXIS 315 (Miss. 2013).

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No-Fault and Uninsured Motorist Automobile Insurance (Matthew Bender Elite Products).

No-Fault and Uninsured Motorist Automobile Insurance (American Bar Association).

§ 83-11-102. Purchase of single-limit, nonstacking uninsured motorist insurance coverage for four or more vehicles in lieu of uninsured motorists coverage for each vehicle.

(1) An insured in an automobile liability policy that covers four (4) or more vehicles may elect to purchase, and an insurer may offer, single-limit, nonstacking uninsured motorist insurance coverage covering all vehicles listed in the policy for a single amount of uninsured motorist coverage. The single uninsured motorist coverage limit must be in an amount of no less than the liability limits required under the Mississippi Motor Vehicle Safety Responsibility Law for four (4) vehicles combined. No matter how many vehicles are listed in or covered by the policy, the policy shall provide only one (1) single limit of uninsured motorist coverage to an injured person, or for property damage, or both, for any one (1) accident. The single limit of uninsured motorist coverage provided by the single-limit, nonstacking uninsured motorist insurance coverage may, where appropriate, be aggregated with or stacked with uninsured motorist insurance coverage available from other policies.

(2) In the course of the sale or issuance of single-limit, nonstacking uninsured motorist insurance coverage, insurers shall inform the named insured or applicant, on a form approved by the Department of Insurance, of the limitation on stacking imposed and that such coverage is an alternative to coverage without such limitation, and such form shall be signed by or on behalf of the named insured or applicant. If this form is signed by or on behalf of a named insured or applicant, it is binding upon all persons insured by the uninsured motorist coverage and it shall be presumed that there was an informed, knowing acceptance of such limitation. When the named insured or applicant has initially accepted such limitation on stacking, such acceptance shall apply to any policy from the same insurer, including sister insurers in the same holding company, which renews the coverage, extends the coverage or changes covered vehicles unless and until the named insured requests in writing a change to stackable uninsured motorist coverage. Endorsements to the coverage language that do not change the uninsured motorist coverage language shall not be considered a new policy for purposes of determining whether a new acceptance form is necessary.

HISTORY: Laws, 2002, ch. 390, § 1; Laws, 2013, ch. 507, § 1, eff from and after July 1, 2013.

Cross References — Mississippi Motor Vehicle Safety Responsibility Law, see §§ 63-15-1 et seq.

§ 83-11-103. Definitions.

As used in this article:

(a) The term "bodily injury" shall include death resulting from such injury.

(b) The term "insured" shall mean the named insured and, while resident of the same household, the spouse of any such named insured and relatives of either, while in a motor vehicle or otherwise, and any person who uses, with the consent, expressed or implied, of the named insured, the motor vehicle to which the policy applies, and a guest in such motor vehicle to which the policy applies, or the personal representative of any of the above. The definition of the term "insured" given in this section shall apply only to the uninsured motorist portion of the policy.

(c) The term "uninsured motor vehicle" shall mean:

(i) A motor vehicle as to which there is no bodily injury liability insurance; or

(ii) A motor vehicle as to which there is such insurance in existence, but the insurance company writing the same has legally denied coverage thereunder or is unable, because of being insolvent at the time of or becoming insolvent during the twelve (12) months following the accident, to make payment with respect to the legal liability of its insured; or

(iii) An insured motor vehicle, when the liability insurer of such vehicle has provided limits of bodily injury liability for its insured which are less than the limits applicable to the injured person provided under his uninsured motorist coverage; or

(iv) A motor vehicle as to which there is no bond or deposit of cash or securities in lieu of such bodily injury and property damage liability insurance or other compliance with the state financial responsibility law, or where there is such bond or deposit of cash or securities, but such bond or deposit is less than the legal liability of the injuring party; or

(v) A motor vehicle of which the owner or operator is unknown; provided that in order for the insured to recover under the endorsement where the owner or operator of any motor vehicle which causes bodily injury to the insured is unknown, actual physical contact must have occurred between the motor vehicle owned or operated by such unknown person and the person or property of the insured; or

(vi) A motor vehicle owned or operated by a person protected by immunity under the Mississippi Tort Claims Act, Title 11, Chapter 46, Mississippi Code of 1972, if the insured has exhausted all administrative remedies under that chapter.

No vehicle shall be considered uninsured that is owned by the United States government and against which a claim may be made under the Federal Tort Claims Act, as amended.

HISTORY: Codes, 1942, § 8285-52; Laws, 1966, ch. 524, § 2; Laws, 1979, ch. 429, § 1; Laws, 2009, ch. 451, § 1, eff from and after July 1, 2009.

Cross References — Application of this section to the exemption from liability of volunteers and sports officials, see § 95-9-5.

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JUDICIAL DECISIONS

ANALYSIS

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1. In general.

Summary judgment was improperly granted to an employer's uninsured motorist insurer in a coverage action brought an employee who was attacked by a former boyfriend when she was getting into her company vehicle because a factual dispute existed as to whether the employee was an insured as defined under Miss. Code Ann. § 83-11-103(b). Thomas v. Jones, 23 So. 3d 575, 2009 Miss. App. LEXIS 518 (Miss. Ct. App. 2009).

Where a passenger was injured, the passenger did not demonstrate that the insured driver was an underinsured motorist under the standard set forth by the Mississippi Supreme Court, which required a comparison of the tortfeasor's liability coverage and the personal coverage carried by, or available to the injured party, nor did the passenger demonstrated good reason to abandon that standard; thus, summary judgment for the insurer on the passenger's claim for underinsured motorist benefits was proper. Byrd v. Hutchinson, 876 So. 2d 1092, 2004 Miss. App. LEXIS 612 (Miss. Ct. App. 2004).

Insureds were entitled to uninsured motorist benefits where a motorist's single liability limit of $ 300,000 was equivalent to a per-accident limit; comparing the motorist's limit to the per-accident limit, rather than the per-person limit, of the insureds' policy, the motorist's vehicle was considered an underinsured motor vehicle under Miss. Code Ann. § 83-11-103(c)(iii). Wise v. United Servs. Auto. Ass'n, 861 So. 2d 308, 2003 Miss. LEXIS 510 (Miss. 2003).

As a permissive user of an employer's insured automobile, the insured was within the Miss. Code Ann. § 83-11-103(b) definition of an "insured," and was therefore entitled to uninsured motorist coverage under the insurer's policy; the policy provision was therefore an invalid basis for the denial of uninsured motorist coverage to the insured. Owen v. Universal Underwriters Ins. Co., 252 F. Supp. 2d 324, 2003 U.S. Dist. LEXIS 5386 (S.D. Miss. 2003).

Where school bus was not yet in sight, the children had not begun the boarding of the bus simply by waiting for it at the bus stop; as children were not using the bus, they were not insureds under the policy and were not entitled to underinsured motorist benefits. Walley v. Coregis Ins. Co., 822 So. 2d 902, 2002 Miss. LEXIS 170 (Miss. 2002).

The six year old plaintiff was an "insured" within the meaning of the statute where he was struck by an uninsured vehicle while he was walking from his home to board a parked school bus 141 feet away. Johnson by & Through Blocket v. United States Fid. & Guar. Ins. Co., 726 So. 2d 167, 1998 Miss. LEXIS 547 (Miss. 1998).

The plaintiff's decedent, an employee of a tire store, was riding in a "covered vehicle" because it was a vehicle insured under the liability provisions of the policy at issue. Crane v. Liberty Mut. Ins. Co., 19 F. Supp. 2d 654, 1998 U.S. Dist. LEXIS 16030 (S.D. Miss. 1998).

Plan of self-insurance is not "liability insurance' for purpose of determining whether tort-feasor is "uninsured motorist' under Perry by & Through Perry v. Nationwide Gen. Ins. Co., 700 So. 2d 600, 1997 Miss. LEXIS 461 (Miss. 1997).

In determining whether tortfeasor is properly considered to be uninsured motorist with regard to particular uninsured motorist (UM) insured, limits of tortfeasor's liability insurance, rather than amount actually available to particular UM insured, should be compared to stacked total of UM benefits applicable to UM insured. Fidelity & Guar. Underwriters v. Earnest, 699 So. 2d 585, 1997 Miss. LEXIS 384 (Miss. 1997).

Driver who was friend of named insureds was not "insured" and, therefore, was not entitled to uninsured motorist (UM) benefits under policies on vehicles not involved in accident; policies defined "insured" to mean permissive user or guest while occupying insured automobile, and driver was not permissible driver of any vehicles not involved in accident. Mississippi Farm Bureau Cas. Ins. Co. v. Curtis, 678 So. 2d 983, 1996 Miss. LEXIS 409 (Miss. 1996), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Mississippi Municipal Liability Plan of self-insurance, authorized by § 11-46-17(5), is not "insurance" within meaning of § 83-11-103(c)(i), which defines uninsured motor vehicle to include vehicle to which there is no bodily injury liability insurance. Coleman v. American Mfrs. Mut. Ins. Co., 930 F. Supp. 255, 1996 U.S. Dist. LEXIS 8961 (N.D. Miss. 1996).

Section 83-11-103(c)(iv), which defines uninsured motor vehicle to include vehicle to which there is no bond or deposit of cash or securities or other compliance with financial responsibility law (§ 63-15-5), does not apply to municipal vehicle; "bond or deposit of cash" referred to in statute must be more than reserve of funds set aside such as bank account or monies placed with Mississippi Municipal Liability Plan, but must actually comply with financial responsibility law. Coleman v. American Mfrs. Mut. Ins. Co., 930 F. Supp. 255, 1996 U.S. Dist. LEXIS 8961 (N.D. Miss. 1996).

In determining whether a person is a "resident" of an insured's household for purposes of uninsured motorist coverage, the court should consider: (1) the subjective or declared intent of the person remaining, either permanently or for an indefinite or unlimited period, in the place he or she contends is his or her "household," (2) the formality or informality of the relationship between such person and the members of the household, and (3) whether the person alleging his or her residence to be a particular household has another place of lodging; however, one may have more than one "residence," making that person a "resident" of more than one locale. Johnson v. Preferred Risk Auto. Ins. Co., 659 So. 2d 866, 1995 Miss. LEXIS 388 (Miss. 1995).

Married adults were "residents" of their respective parents' households on the date of an accident for purposes of uninsured motorist coverage, even though they were only temporarily staying with their respective parents until such time as they could move, and they had plans to move to a house in another state later that month (overruling Goens v. Arinder (Miss. 1964) 161 So. 2d 509). Johnson v. Preferred Risk Auto. Ins. Co., 659 So. 2d 866, 1995 Miss. LEXIS 388 (Miss. 1995).

Under the Mississippi Uninsured Motorist Act (§§ 83-11-101 et seq), a minor child of divorced parents may be considered a "resident of the same household" of both parents, since a child is a resident of both parents' households until he or she reaches the age of majority or becomes fully emancipated. Aetna Casualty & Sur. Co. v. Williams, 623 So. 2d 1005, 1993 Miss. LEXIS 388 (Miss. 1993).

Under §§ 83-11-101 and 83-11-103, when an automobile owner accepts an insurer's offer of uninsured motorist coverage, both the owner and his or her guests are insured for bodily and property damage arising from the negligent operation of an uninsured vehicle. Brown v. Hartford Ins. Co., 606 So. 2d 122, 1992 Miss. LEXIS 558 (Miss. 1992).

An insured's father, mother and sister were not "insureds" within the uninsured motorist coverage of the insured's automobile insurance policy where the father, mother and sister did not reside in the same household with the insured, and therefore were not "relatives" within the meaning of the policy; since nothing in the policy expanded the word "insured" beyond the statutory definition found in § 83-11-103(b), which defines the term "insured" as a "resident of the same household," the statutory definition controlled. Gunn v. Principal Casualty Ins. Co., 605 So. 2d 741, 1992 Miss. LEXIS 318 (Miss. 1992).

As prerequisite to successful claim for underinsured motorist benefits, plaintiffs must establish that insured motor vehicle is, in fact, underinsured. Coomes v. State Farm Mut. Auto. Ins. Co., 788 F. Supp. 916, 1992 U.S. Dist. LEXIS 5460 (S.D. Miss. 1992).

Despite contention of insured that she was seeking payment of "excess" insurance coverage rather than underinsured motorist coverage, insurer was not required to pay under policy provision stating that "coverage applies as excess to any uninsured motor vehicle coverage," where vehicle in which insured was riding when she incurred injuries was neither uninsured nor underinsured; coverage applied as excess coverage only when insurance policy's uninsured motorist coverage was invoked, and simply did not apply in absence of uninsured motor vehicle. Coomes v. State Farm Mut. Auto. Ins. Co., 788 F. Supp. 916, 1992 U.S. Dist. LEXIS 5460 (S.D. Miss. 1992).

A tortfeasor whose automobile struck a vehicle driven by an insured was an "uninsured motorist" for subrogation purposes under the Uninsured Motorist Act pursuant to § 83-11-103(c)(iii), even though the tortfeasor was "underinsured" in fact. St. Paul Property & Liability Ins. Co. v. Nance, 577 So. 2d 1238, 1991 Miss. LEXIS 183 (Miss. 1991).

An employee was "using" an insured vehicle at the time of an accident, and was therefore an "insured" under an automobile liability policy, where the employee was driving the insured truck to a job site when he stopped on the highway to assist in the repair of a disabled company crane, he exited the truck and crawled beneath the crane to determine if it could be repaired, and he was struck by a van driven by an uninsured motorist as he was crawling from beneath the crane. Directing and assisting his co -employees in repairing the disabled crane that was crucial to the performance of their job was a necessary part of the employee's duties as a foreman, and the employee could only accomplish this part of his job by removing himself from the insured truck. Stopping to repair the crane was a necessary aspect of the truck's operation, and it could not be said that temporarily exiting the insured vehicle constituted an abandonment of its use. Harris v. Magee, 573 So. 2d 646, 1990 Miss. LEXIS 900 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

An employee who was using his employer's vehicle with the consent of the employer was not a "named insured" for purposes of uninsured motorist coverage, but rather was a Class II insured. Harris v. Magee, 573 So. 2d 646, 1990 Miss. LEXIS 900 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

The statutory definition of an underinsured motorist contained in § 83-11-103(c)(iii) cannot be read in isolation, but must be interpreted in light of other pertinent provisions within the uninsured motorist scheme, such as § 83-11-101(1). Since § 83-11-101(1) prohibits issuance of uninsured coverage in an amount greater than the liability coverage provided for in the policy, in one-vehicle accidents, unless the injured person, as referred to in § 83-11-103(c)(iii), is allowed to stack his or her uninsured motorist coverage with the coverage on the insured motor vehicle, the insured motor vehicle would never be underinsured because the uninsured motorist limits on such a vehicle would never exceed its liability limits. Thiac v. State Farm Mut. Auto. Ins. Co., 569 So. 2d 1217, 1990 Miss. LEXIS 670 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Insurance company has no liability to insured under uninsured motorist provisions of insured's automobile policy where insurance companies against whom insured made claims did not deny coverage to their insureds, but simply denied liability to plaintiff insured under facts of accident; insured may recover under her policy if, in accordance with § 83-11-103(c)(iii), she establishes that one of two parties with which she was involved in accident, which party was underinsured, was negligent, that that party's negligence was sole proximate cause of insured's damages, and that insured's damages are in excess of party's limit of liability. Allstate Ins. Co. v. Hilbun, 703 F. Supp. 533, 1988 U.S. Dist. LEXIS 15303 (S.D. Miss. 1988).

Uninsured motorist coverage is available despite exclusion in policy that insured vehicle cannot be uninsured so as to prevent insured claiming uninsured motorist benefit after being denied recovery based on other policy exclusions, such as household exclusion; uninsured motorist coverage may be stacked. Allstate Ins. Co. v. Randall, 753 F.2d 441, 1985 U.S. App. LEXIS 28113 (5th Cir. Miss. 1985).

Where an insured, who was injured while riding as a passenger in her own car, brought suit against her insurance company to recover under her uninsured motorist coverage, and where her policy expressly forbade her to make a claim based on liability of an uninsured operator of her own vehicle, the Supreme Court held would find that, in light of the fact that the driver was an uninsured motorist, it was against public policy of the state, as expressed by the legislature under § 83-11-103, to allow the insurance company to exclude the insured from coverage. State Farm Mut. Auto. Ins. Co. v. Nester, 459 So. 2d 787, 1984 Miss. LEXIS 1971 (Miss. 1984), overruled, Burns v. Burns, 518 So. 2d 1205, 1988 Miss. LEXIS 18 (Miss. 1988).

A guest passenger on a motorcycle who is killed as the result of a collision with an uninsured motorist was an "insured" under the second definition set out in § 83-11-103(b), where she was an occupant of an uninsured vehicle and was not a relative living in the same household with the named insured under the policy, and as such she was not covered under the policy, in that the motorcycle was not a "temporary substitute automobile" as authorized under policy provisions. Aetna Casualty & Surety Co. v. Barker, 451 So. 2d 731, 1984 Miss. LEXIS 1750 (Miss. 1984), overruled in part, Wickline v. United States Fidelity & Guaranty Co., 1988 Miss. LEXIS 247 (Miss. Apr. 6, 1988).

A pickup truck owned by an insured was an uninsured vehicle within the meaning of this statute where the truck was driven by an employee who was excluded from coverage under the insured's policy by a cross-employee exclusion clause and who had no other liability policy that would cover his negligent operation of the vehicle; a policy clause purporting to exclude the truck from uninsured vehicle status was ineffective as being clearly in conflict with the Uninsured Motorist Vehicle Act. Preferred Risk Mut. Ins. Co. v. Poole, 411 F. Supp. 429, 1976 U.S. Dist. LEXIS 16167 (N.D. Miss.), aff'd, 539 F.2d 574, 1976 U.S. App. LEXIS 6975 (5th Cir. Miss. 1976).

Where an automobile liability insurance policy contained a clause excluding bodily injuries to an insured while occupying or through being struck by a land motor vehicle owned by a named insured or any resident of the same household, if such vehicle was not an owned motor vehicle, and insured's son was clearly within the terms of the exclusionary provision of the policy since he was riding a motorcycle which he owned when he was struck by an uninsured motorist, and his motorcycle was not an "owned motor vehicle" as set out in the declaration of the motor vehicle insured, nevertheless the exclusionary clause of the policy violated the public policy of Mississippi by conflicting with the Mississippi statute requiring all automobile liability insurance policies to contain an uninsured motorist provision. Lowery v. State Farm Mut. Auto Ins. Co., 285 So. 2d 767, 1973 Miss. LEXIS 1303 (Miss. 1973), overruled in part, Wickline v. United States Fidelity & Guaranty Co., 1988 Miss. LEXIS 247 (Miss. Apr. 6, 1988).

A motorcycle insured against bodily injury liability by a policy which excluded from coverage "bodily injury to any person while on or getting on or alighting from the insured vehicle" was an uninsured motor vehicle as to a motorcycle passenger injured when the motorcycle was involved in an intersection collision with an automobile. Harthcock v. State Farm Mut. Auto. Ins. Co., 248 So. 2d 456, 1971 Miss. LEXIS 1473 (Miss. 1971).

2. Beneficiaries.

Where the insured's daughter had moved away from home to attend college but maintained a room in his home and had expressed the intention to move back to his home the same weekend she was killed in an automobile accident, the legislature's choice of the more inclusive term "resident" among those potentially covered by uninsured motorist benefits allowed the possibility the insured could recover such benefits. McLeod v. Allstate Ins. Co., 789 So. 2d 806, 2001 Miss. LEXIS 166 (Miss. 2001).

Benefits payable under uninsured motorist insurance policy due to injuries resulting in death of insured need not be paid to persons designated under wrongful death statute (§ 11-7-13), but may be paid to surviving spouse in accordance with "facility of payment" clause. Overstreet v. Allstate Ins. Co., 474 So. 2d 572, 1985 Miss. LEXIS 2195 (Miss. 1985).

3. Exclusion of or offset against benefits payable under other provisions or policies.

Grant of summary judgment in favor of the insurer in the operator's action concerning an offset against the insurer's uninsured motorist coverage limits was proper pursuant to the Uninsured Motorist Act (Act), Miss. Code Ann. § 83-11-101 et seq., where the operator received $ 600,000 from another insurer and had therefore already received far more than the minimum $ 10,000 contracted for and required by the Act. Additionally, the offset clause did not provide an offset for sums paid to parties other than the operator. Jeffcoat v. Am. Nat'l Prop. & Cas. Co., 919 So. 2d 982, 2005 Miss. App. LEXIS 421 (Miss. Ct. App. 2005).

Insurance company was no longer liable for any uninsured motorist (UM) benefits where the insureds admitted that they had been paid, through settlements with a bar that served a motorist alcohol, an amount that exceeded their available UM benefits; the insurance company was not liable for the difference between the total available UM benefits and the amount paid by the driver's liability carrier. Wise v. United Servs. Auto. Ass'n, 861 So. 2d 308, 2003 Miss. LEXIS 510 (Miss. 2003).

Underinsured motorist carrier for tortfeasor was entitled to offset its $25,000 UM limits applicable to injured passenger by $16,666.67 in liability payments it made to that passenger, but it was not entitled to offset for payments made by other parties. Fidelity & Guar. Underwriters v. Earnest, 699 So. 2d 585, 1997 Miss. LEXIS 384 (Miss. 1997).

Where an injured guest-passenger's uninsured or underinsured motorist (UM) policy only allowed the insurer to offset amounts actually paid by it, the host driver's UM insurer was entitled to take its contractual liability insurance offset before the injured passenger's UM insurer, and the passenger's insurer was not entitled to pro-ration of the offset provision of the driver's policy. Dixie Ins. Co. v. State Farm Mut. Auto. Ins. Co., 614 So. 2d 918, 1992 Miss. LEXIS 823 (Miss. 1992).

A workers' compensation carrier, which was also the uninsured motorist carrier, was not entitled to a credit on behalf of a deceased employee, where the employee's beneficiary had failed to recover anything from the party responsible for the employee's death. Harris v. Magee, 573 So. 2d 646, 1990 Miss. LEXIS 900 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

A host vehicle, in which a guest passenger was riding when the vehicle left the road and hit a tree, was not an uninsured vehicle for the purposes of § 83-11-103(c)(iii) where the guest passenger had no uninsured coverage of her own and the host vehicle provided liability coverage of $25,000, so that the liability coverage was not less than the guest's uninsured motorist coverage. Although a guest passenger is permitted to stack his or her own uninsured motorist coverage with the uninsured motorist coverage on the host vehicle for the purpose of qualifying the host vehicle as underinsured, the guest passenger was not allowed to stack the host vehicle's policy to qualify the vehicle as underinsured since the guest had no insurance of her own. To allow her to stack the host vehicle's policy for the purposes of determining whether the vehicle was underinsured would be contrary to the legislative purpose in adopting the underinsured motor vehicle concept as part of Mississippi's statutory scheme; the guest passenger could have contracted with her carrier for excess coverage beyond the statutory minimum, thereby rendering the host vehicle underinsured. For the purpose of establishing whether an insured host vehicle is, in fact, underinsured, the court looks no further than the guest passenger's own coverage and the coverage on the host vehicle. Thiac v. State Farm Mut. Auto. Ins. Co., 569 So. 2d 1217, 1990 Miss. LEXIS 670 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

An injured passenger was not entitled to collect uninsured motorist coverage provided by a policy on his own automobile where he had received benefits under the driver's policy even though he had received only $436.34 from the driver's insurance coverage and it was undisputed that the injuries received by the passenger were substantial enough to support an award of damages in the amount $9,536.66. Washington v. Georgia American Ins. Co., 540 So. 2d 22, 1989 Miss. LEXIS 147 (Miss. 1989).

In creating underinsured motorist coverage by amendment of § 83-11-103, legislature did not intend to abrogate rights of underinsured motorist carriers to subrogation as provided in § 83-11-107 and, therefore, underinsured motorist carrier may be allowed offset for payments by underinsured tortfeasor's liability carrier. State Farm Mut. Auto. Ins. Co. v. Kuehling, 475 So. 2d 1159, 1985 Miss. LEXIS 2235 (Miss. 1985), limited, Fidelity & Guar. Underwriters v. Earnest, 699 So. 2d 585, 1997 Miss. LEXIS 384 (Miss. 1997).

Although automobile of tortfeasor who carries liability insurance in amount less than amount of coverage available to injured person under that person's uninsured motorist provisions of injured person's policies is "uninsured motor vehicle" by statutory definition (§ 83-11-103), uninsured motorist coverage may be reduced by offset for sums paid by another company on behalf of under-insured driver where uninsured motorist provision so provides. State Farm Mut. Auto. Ins. Co. v. Eubanks, 620 F. Supp. 17, 1985 U.S. Dist. LEXIS 17700 (N.D. Miss. 1985), aff'd, 785 F.2d 1346, 1986 U.S. App. LEXIS 23704 (5th Cir. Miss. 1986).

4. "Actual physical contact."

Under the uninsured policy issued to the decedent, the insurer properly denied the widow benefits as a witness to the auto accident never saw the other car actually come into physical contact with decedent's car. Mitchell v. United Servs. Auto. Ass'n, 831 So. 2d 1144, 2002 Miss. LEXIS 408 (Miss. 2002).

Where there was no actual physical contact between the decedent's vehicle and another vehicle driven by an unidentified motorist which forced it off the road, resulting in the accident which killed the decedent, subdivision (v) controlled and there could be no recovery under the decedent's insurance policy. Massachusetts Bay Ins. Co. v. Joyner, 763 So. 2d 877, 2000 Miss. LEXIS 175 (Miss. 2000).

An insured's recovery under an uninsured motorist policy was precluded by § 83-11-103(c) where no actual physical contact occurred between the motor vehicle operated by the uninsured motorist and the insured's vehicle, despite the insured's argument that public policy demanded that they be entitled to recover if they proved the negligence of the uninsured motorist plus the requisite causation. Anderson v. State Farm Mut. Auto. Ins. Co., 555 So. 2d 733, 1990 Miss. LEXIS 3 (Miss. 1990).

Truck striking object lying in lane of traffic and propelling it into insured's windshield constitutes physical contact within meaning of statute, which includes physical contact of one vehicle with intermediate vehicle or other object which, in same mechanism of accident, strikes insured's vehicle; injury causing impact must have complete, proximate, direct, and timely relationship with first impact between hit-and-run vehicle and intermediate vehicle, in effect meaning impact must be result of unbroken chain of events with clearly definable beginning and ending occurring in continuous sequence. Southern Farm Bureau Casualty Ins. Co. v. Brewer, 507 So. 2d 369, 1987 Miss. LEXIS 2528 (Miss. 1987).

5. Exhaustion of proceeds available under policy.

A tortfeasor did not become an "uninsured motorist" with respect to an injured party such that the injured party's uninsured motorist coverage would apply, where multiple claimants under the tortfeasor's liability policy, other than the injured party, had totally exhausted the available proceeds, but the limit of liability provided by the tortfeasor's insurer was not less than the limit provided by the injured party's own uninsured motorist coverage. Cossitt v. Federated Guaranty Mut. Ins. Co., 541 So. 2d 436, 1989 Miss. LEXIS 138 (Miss. 1989).

6. Aggregating or "stacking" of benefits.

Passenger was permitted to stack the uninsured motorist (UM) benefits of other vehicles covered under the same insurance policy as the host car because Mississippi allowed insurers to include express anti-stacking provisions in insurance policy contracts, but the insurer did not include such a provision in the insurance policy. Therefore, the absence of an express prohibition on stacking allowed the passenger to stack the UM benefits of the vehicles insured under the same policy. Brewer v. Miss. Farm Bureau Cas. Ins. Co., 2021 Miss. App. LEXIS 225 (Miss. Ct. App. May 25, 2021).

Because the employee was a Class II insured under the insurer's policy, Miss. Code Ann. § 83-11-103(b), he did not have the right to stack an employer's uninsured motorist coverage; the law at the time of the employee's injuries was not that a second class insured could stack all coverages under his employer's uninsured motorist fleet coverage. Deaton v. Miss. Farm Bureau Cas. Ins. Co., 994 So. 2d 164, 2008 Miss. LEXIS 574 (Miss. 2008).

In light of Miss. Code Ann. § 83-11-103(c)(iii), a court compared the liability limits of $25,000 in a policy purchased by the owner of a vehicle in which a 17-year-old was riding, to all the uninsured motorist (UM) coverage to which she was entitled. The statutory definition made the vehicle uninsured (or more aptly, underinsured) because the $115,000 of available UM coverage far exceeded the $25,000 of liability coverage. Essinger v. Liberty Mut. Fire Ins. Co., 529 F.3d 264, 2008 U.S. App. LEXIS 10784 (5th Cir. Miss. 2008).

Where plaintiff was injured in an accident while driving a company car, defendant insurers were entitled to summary judgment on plaintiff's claims for underinsured coverage because plaintiff, who was not listed as a named insured on the fleet policy, could not stack the underinsured motorist coverages on all 138 of the vehicles owned by his employer and insured by his employer under that policy in order to determine that the tortfeasor's vehicle was underinsured. Nettles v. Travelers Prop. Cas. Ins. Co., 375 F. Supp. 2d 489, 2005 U.S. Dist. LEXIS 17846 (S.D. Miss. 2005), amended, 2005 U.S. Dist. LEXIS 17848 (S.D. Miss. Feb. 14, 2005).

Summary judgment was properly granted to two insurers because an employee's uninsured motorist coverage was insufficient to entitle him to uninsured motorist benefits; under Miss. Code Ann. §§ 83-11-101, 83-11-103, the Class II insured had no personal uninsured motorist benefits to stack with a business policy, and an umbrella policy did not count. Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Under Miss. Code Ann. § 83-11-103(c)(iii) an injured insured may not stack the uninsured motorist coverage of other "fleet" vehicles not involved in an accident to have a third-party tortfeasor's vehicle declared underinsured where the injured party did not insure the fleet in question. Mascarella v. United States Fid. & Guar. Co., 833 So. 2d 575, 2002 Miss. LEXIS 262 (Miss. 2002).

Insured parties, who were injured while driving one of their employer's three vehicles, were not entitled under Miss. Code Ann. § 83-11-103(b) (1999) to stack the uninsured motorist provisions for the employer's vehicles, because the employer's vehicles were covered by separate policies. Glennon v. State Farm Mut. Auto. Ins. Co., 812 So. 2d 927, 2002 Miss. LEXIS 17 (Miss. 2002), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Stacking of the injured person's limits was allowed for the purpose of qualifying the tortfeasor as an underinsured motorist. McDaniel v. Shaklee U.S., Inc., 807 So. 2d 393, 2001 Miss. LEXIS 287 (Miss. 2001), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

A passenger who is injured in a multiple vehicle collision and is an insured within his or her own uninsured motorist coverage is not entitled to aggregate all the uninsured motorist coverage, which is applicable to all the other injured persons in the collision, for the purpose of determining the underinsured/uninsured status of the negligent driver. Estep v. Allstate Ins. Co. (In re Lacy), 649 So. 2d 195, 1995 Miss. LEXIS 39 (Miss. 1995).

Guest passengers who were in an insured vehicle at the time of a collision with an uninsured motorist were not entitled to stack 5 uninsured motorist coverages sold by the insurer to the owner of the vehicle in which they were passengers where they were Class 2 "insureds" under the policy, and were therefore limited to the uninsured motorist coverage on the vehicle in which they were passengers. Duncan v. Duncan, 634 So. 2d 108, 1994 Miss. LEXIS 130 (Miss. 1994).

In a wrongful death action brought by the parents of a passenger who was killed in a motor vehicle accident, the parents were entitled to receive only the uninsured motor vehicle (UM) coverage provided by their own policies and the policy covering the accident vehicle, and were not entitled to the UM coverage provided by 2 other insurance policies issued to the owners of the accident vehicle which covered 2 other automobiles; the parents were entitled to stack the UM coverage provided by the policies in which the passenger met the definition of an "insured" either under the terms of the policy and/or the UM statute, and the passenger was an "insured" only under the policy covering the accident vehicle since she was a guest passenger in that vehicle but was not a guest passenger in either of the other 2 vehicles covered under the other policies issued to the owners. State Farm Mut. Auto. Ins. Co. v. Davis, 613 So. 2d 1179, 1992 Miss. LEXIS 829 (Miss. 1992), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

An insured was not entitled to stack uninsured motorist coverages where the policies providing the coverages prohibited stacking of coverages in excess of the statutory minimum. Casualty Reciprocal Exch. v. Federal Ins. Co., 608 So. 2d 1258 (Miss. 1992).

Guest passenger who is injured while occupant of an underinsured motor vehicle may not recover from uninsured motorist insurance carried by named insured on another vehicle not involved in accident in question, where insurance on such other vehicle is provided under separate insurance policy; such guest passenger is not "insured" and is not entitled to stack coverage under policy. Thomas v. State Farm Mut. Auto. Ins. Co., 796 F. Supp. 231, 1992 U.S. Dist. LEXIS 9432 (S.D. Miss. 1992).

Guest passenger who was injured while an occupant of underinsured motor vehicle may not recover from uninsured motorist insurance carried by named insured on another vehicle not involved in accident, where insurance on such other vehicle is provided under separate insurance policy, as to which injured person is not an insured. Thomas v. State Farm Mut. Auto. Ins. Co., 796 F. Supp. 231, 1992 U.S. Dist. LEXIS 9432 (S.D. Miss. 1992).

A trial court properly allowed a second class permissive user to stack insured motorist benefits under his employer's commercial fleet policy. Mississippi's statutory scheme does not distinguish a "commercial fleet policy" from any other type of automobile insurance policy, nor is it defined therein, and therefore there is no statutory basis for distinguishing a commercial fleet policy. Harris v. Magee, 573 So. 2d 646, 1990 Miss. LEXIS 900 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

A Class II insured who was using his employer's insured vehicle at the time of the accident was entitled to stack uninsured motorist benefits under his employer's commercial fleet policy. There is no basis for distinguishing a "commercial fleet policy" from any other type of auto insurance policy. Uninsured motorist coverage is designed to provide innocent injured motorists a means to recover all sums to which they are entitled from an uninsured motorist. The statute is to be liberally construed so as to achieve compensation. Uninsured motorist coverage is available to an injured insured until all sums which he or she is entitled to recover from the uninsured motorist have been recovered. Section 83-11-103 specifically refers to use of a "motor vehicle," which indicates that stacking is necessarily limited to those "motor vehicles" listed in the schedule of covered vehicles. Harris v. Magee, 573 So. 2d 646, 1990 Miss. LEXIS 900 (Miss. 1990), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Taxicab driver injured in course of employment qualified as second class insured under automobile liability policy covering cab which he was driving; as second class insured taxi driver could stack uninsured motorist benefits. Curry v. Travelers Indem. Co., 728 F. Supp. 1299, 1989 U.S. Dist. LEXIS 15899 (S.D. Miss. 1989).

Although insurer's maximum liability is aggregate of all uninsured motorist policies under which injured person is covered, "per person" limitations in policies refer to injured person only, not to persons who may make claim under policy. State Farm Mut. Auto. Ins. Co. v. Eubanks, 620 F. Supp. 17, 1985 U.S. Dist. LEXIS 17700 (N.D. Miss. 1985), aff'd, 785 F.2d 1346, 1986 U.S. App. LEXIS 23704 (5th Cir. Miss. 1986).

Uninsured motorist coverage may be stacked. Allstate Ins. Co. v. Randall, 753 F.2d 441, 1985 U.S. App. LEXIS 28113 (5th Cir. Miss. 1985).

7. Applicability to farm tractors.

Farm tractor is not vehicle designed for use mainly on public roads and is instead vehicle designed mainly for use off public roads. Wilcher v. Michigan Mut. Ins. Co., 691 F. Supp. 1019, 1988 U.S. Dist. LEXIS 9020 (S.D. Miss. 1988).

8. Uninsured motorist.

Until an insurer had knowledge that another insurance company had denied coverage, the insurer had no reason to believe that there was an uninsured motorist claim, for purposes of Miss. Code Ann. § 83-11-103(c)(ii); the insurer had a legitimate reason not to pursue the uninsured motorist claim sooner and was properly granted summary judgment. Kendrick v. Miss. Farm Bureau Ins., 996 So. 2d 132, 2008 Miss. App. LEXIS 566 (Miss. Ct. App. 2008).

9. Miscellaneous.

In a coverage dispute, a brother was not entitled to uninsured motorist benefits under a sister's policy with an insurer because the brother was not a resident of the sister's household nor she in his household, and as such, the brother was not an "insured" as defined in the Uninsured Motorist Act, Miss. Code Ann. § 83-11-103(b); although the sister helped take care of the brother in his residence on a periodic basis after an accident, the sister never intended to abandon her residence, which was across the street from the brother's. Robinson v. State Farm Mut. Auto. Ins. Co., 52 So. 3d 416, 2010 Miss. App. LEXIS 560 (Miss. Ct. App. 2010), cert. dismissed, 56 So. 3d 574, 2011 Miss. LEXIS 159 (Miss. 2011).

Even though Miss. Code Ann. § 83-11-103 provided that an unemancipated minor was a household resident of both the custodial and noncustodial parent for purposes of uninsured motorist insurance, there was no such limit for parties to contract for liability insurance. Thus, a minor primarily living with his father was not an insured under his stepfather's liability policy. Plunkett v. State Farm Mut. Auto. Ins. Co., 625 F. Supp. 2d 321, 2009 U.S. Dist. LEXIS 31355 (N.D. Miss. 2009), rev'd, 347 Fed. Appx. 994, 2009 U.S. App. LEXIS 22809 (5th Cir. Miss. 2009), transferred, 2011 U.S. Dist. LEXIS 73472 (N.D. Miss. July 7, 2011).

RESEARCH REFERENCES

ALR.

Who is "member" or "resident" of same "family" or "household," within no-fault or uninsured motorist provisions of motor vehicle insurance policy. 96 A.L.R.3d 804.

Unborn child as insured or injured person within meaning of insurance policy. 15 A.L.R.4th 548.

Operation or use of vehicle outside scope of permission as rending it uninsured within meaning of uninsured motorist coverage. 17 A.L.R.4th 1322.

Validity of exclusion in automobile insurance policy precluding recovery of no-fault benefits for injuries arising out of the ownership, maintenance, or use of an uninsured vehicle owned by an insured. 18 A.L.R.4th 632.

Uninsured motorist coverage: validity of exclusion of injuries sustained by insured while occupying "owned" vehicle not insured by policy. 30 A.L.R.4th 172.

Right of liability insurer or uninsured motorist insurer to invoke defense based on insured's tort immunity arising out of marital or other close family relationship to injured party. 36 A.L.R.4th 747.

Uninsured motorist insurance: injuries to motorcyclist as within affirmative or exclusionary terms of automobile insurance policy. 46 A.L.R.4th 771.

Validity, under insurance statutes, of coverage exclusion for injury to or death of insured's family or household members. 52 A.L.R.4th 18.

Right of insured, precluded from recovering against owner or operator of uninsured motor vehicle because of governmental immunity, to recover uninsured motorist benefits. 55 A.L.R.4th 806.

What constitutes "motor vehicle" for purposes of no-fault insurance. 73 A.L.R.4th 1053.

Validity, construction, and application of exclusion of government vehicles from uninsured – motorist provision. 58 A.L.R.5th 511.

Am. Jur.

7 Am. Jur. 2d, Automobile Insurance § 136.

Law Reviews.

1979 Mississippi Supreme Court Review: Insurance. 50 Miss. L. J. 813.

Phillips, A Guide to Uninsured Motorist Insurance Law in Mississippi. 52 Miss. L. J. 255.

1984 Mississippi Supreme Court Review: Insurance. 55 Miss. L. J. 128.

1985 Mississippi Supreme Court Review-Miscellaneous. 55 Miss. L. J. 827.

1987 Mississippi Supreme Court Review, Insurance. 57 Miss. L. J. 550.

1989 Mississippi Supreme Court Review: Insurance. 59 Miss. L. J. 906.

Recent Decision: Automobile Insurance–Mississippi Uninsured Motorist Statute–Actual Physical Contact Required Where Claim Involves Unidentified Motorist, 72 Miss. L.J. 1121, Spring, 2003.

§ 83-11-105. Action against owner or operator of uninsured vehicle.

In the event the owner or operator of the uninsured vehicle causing injury or death is known and action is brought against said owner or operator by the named insured as defined by said policy, then a copy of the process served upon the owner or operator shall also be served by the circuit clerk mailing, registered mail, a copy of the process to the insurance company issuing the policy providing the uninsured motorist coverage as prescribed by law.

If the owner or operator of any motor vehicle which causes bodily injury to the insured be unknown, the insured or someone on his behalf, or in the event of a death claim, someone on behalf of the party having such claim in order for the insured to recover under the endorsement, shall report the accident as required by Section 63-15-9, Mississippi Code of 1972.

HISTORY: Codes, 1942, § 8285-53; Laws, 1966, ch. 524, § 3, eff from and after passage (approved May 18, 1966).

Editor's Notes — Section 63-15-9, referred to in this section, was repealed by Laws of 2003, Chapter 485, § 2, effective from and after July 1, 2003.

Cross References — Application of this section to the exemption from liability of volunteers and sports officials, see § 95-9-5.

JUDICIAL DECISIONS

1. In general.

Once someone who possesses uninsured motorist coverage knows, or reasonably should know, that the damages claimed to have been suffered exceed the limits of insurance available to the alleged tortfeasor, the cause of action against the uninsured motorist carrier has accrued, and it is at this point in time that a potential plaintiff has a legally enforceable claim against the uninsured motorist carrier. Jackson v. State Farm Mut. Auto. Ins. Co., 852 So. 2d 641, 2003 Miss. App. LEXIS 70 (Miss. Ct. App. 2003), rev'd, 880 So. 2d 336, 2004 Miss. LEXIS 1053 (Miss. 2004).

Though the insured and the insured's wife failed to comply with the notice provisions under their policy, by not giving notice of a claim for underinsured motorist coverage for almost five years, due to a late finding that the limits on the tortfeasor's policy would be insufficient, that omission was not outcome determinative; despite the late notice, the question of prejudice remained a fact issue, and summary judgment for the insurer was improper. Jackson v. State Farm Mut. Auto. Ins. Co., 852 So. 2d 641, 2003 Miss. App. LEXIS 70 (Miss. Ct. App. 2003), rev'd, 880 So. 2d 336, 2004 Miss. LEXIS 1053 (Miss. 2004).

In a dispute over uninsured motorist coverage, a guest passenger in an automobile was entitled to aggregate the owner's coverage on the owner's other vehicles for the purpose of qualifying the tortfeasor as an uninsured motorist. Wickline v. United States Fidelity & Guaranty Co., 530 So. 2d 708, 1988 Miss. LEXIS 448 (Miss. 1988), overruled in part, Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

The judgment recovered in a case brought by the driver of the insured vehicle against the driver of the other vehicle, to which the insurer was not a party, was not res judicata against the insurer and in no way bound it in an action brought by the driver of the insured vehicle to collect under the uninsured motorist clause. State Farm Fire & Casualty Co. v. Wightwick, 320 So. 2d 373, 1975 Miss. LEXIS 1490 (Miss. 1975).

Code 1942 § 8285-53 obviously means process in suits begun in Mississippi courts, and it is not a requirement to be performed by clerks of foreign courts. Rampy v. State Farm Mut. Auto. Ins. Co., 278 So. 2d 428, 1973 Miss. LEXIS 1442 (Miss. 1973).

Code 1942 § 8285-53 does not require persons seeking to recover under the uninsured motorist provisions of an automobile liability policy to have given the insurer notice of a previous tort action against the uninsured motorist, unless the insured is a "named insured" in the liability policy, and then only when substantial prejudice to the rights of the insurer would result but for notice to the insurer from a party seeking to recover under the uninsured motorist indorsement on the judgment obtained in the tort action. Rampy v. State Farm Mut. Auto. Ins. Co., 278 So. 2d 428, 1973 Miss. LEXIS 1442 (Miss. 1973).

The burden of proof is upon the insurer to show prejudice because of the failure of the named insured to have process issued. Rampy v. State Farm Mut. Auto. Ins. Co., 278 So. 2d 428, 1973 Miss. LEXIS 1442 (Miss. 1973).

In light of the remedial purpose underlying the Uninsured Motor Vehicles Law, an insurer must demonstrate to the satisfaction of the court that the outcome of the insured's action against an uninsured tortfeasor would have been radically altered had the "named insured" complied with the notice provisions of Code 1942 § 8285-53. Rampy v. State Farm Mut. Auto. Ins. Co., 278 So. 2d 428, 1973 Miss. LEXIS 1442 (Miss. 1973).

Code 1942 § 8285-53 is directory and not mandatory. Rampy v. State Farm Mut. Auto. Ins. Co., 278 So. 2d 428, 1973 Miss. LEXIS 1442 (Miss. 1973).

The failure to give a copy of the process to the insurance company of the original suit against an uninsured motorist does not work a forfeiture of a right to sue the insurance company under the uninsured motorist clause in the contract, unless the judgment obtained is used as the basis of a suit or garnishment against the insurance company sought to be charged. Rampy v. State Farm Mut. Auto. Ins. Co., 278 So. 2d 428, 1973 Miss. LEXIS 1442 (Miss. 1973).

RESEARCH REFERENCES

ALR.

Insured's right to bring direct action against insurer for uninsured motorist benefits. 73 A.L.R.3d 632.

Conflict of laws as to right of insured to maintain under uninsured motorist clause a direct action against a automobile liability insurer. 83 A.L.R.3d 308.

Validity of substituted service of process upon liability insurer of unavailable tortfeasor. 17 A.L.R.4th 918.

Validity of exclusion in automobile insurance policy precluding recovery of no-fault benefits for injuries arising out of the ownership, maintenance, or use of an uninsured vehicle owned by an insured. 18 A.L.R.4th 632.

Validity, construction, and effect of "consent to sue" clauses in uninsured motorist endorsement of automobile insurance policy. 24 A.L.R.4th 1024.

Uninsured motorist insurance: injuries to motorcyclist as within affirmative or exclusionary terms of automobile insurance policy. 46 A.L.R.4th 771.

Punitive damages as within coverage of uninsured or underinsured motorist insurance. 54 A.L.R.4th 1186.

Right of insured, precluded from recovering against owner or operator of uninsured motor vehicle because of governmental immunity, to recover uninsured motorist benefits. 55 A.L.R.4th 806.

Am. Jur.

7 Am. Jur. 2d, Automobile Insurance § 137.

Law Reviews.

Phillips, A Guide to Uninsured Motorist Insurance Law in Mississippi. 52 Miss. L. J. 255.

§ 83-11-107. Subrogation.

An insurer paying a claim under the endorsement or provisions required by Section 83-11-101 or Section 83-11-102 shall be subrogated to the rights of the insured to whom such claim was paid against the person causing such injury, death, or damage to the extent that payment was made, including the proceeds recoverable from the assets of the insolvent insurer. The bringing of an action against the unknown owner or operator, or the conclusion of such an action, shall not constitute a bar to the insured if the identity of the owner or operator who caused the injury or damages complained of becomes known, provided that in any action brought against such owner or operator, the insurance company that has previously made payment as a result of the policyholder's claim against such owner or operator shall be mailed a copy of the summons issued for the defendant or defendants, and that any recovery against such owner or operator shall be paid to the insurance company to the extent that such insurance company paid the named insured in the action brought against such owner or operator, except that such insurance company shall pay its proportionate part of any reasonable costs and expense incurred in connection therewith, including reasonable attorney's fees.

HISTORY: Codes, 1942, § 8285-54; Laws, 1966, ch. 524, § 4; Laws, 2002, ch. 390, § 2, eff from and after July 1, 2002.

Cross References — Application of this section to the exemption from liability of volunteers and sports officials, see § 95-9-5.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Illustrative cases.

1. In general.

Insurer's right to subrogation under Miss. Code Ann. § 83-11-107 does not transform into a right to "equitable indemnification" merely because the limitations period has run on its subrogation right, even where the limitations period expires owing to no fault of the insurer. Miss. Farm Bureau Cas. Ins. Co. v. Orme, 422 F. Supp. 2d 685, 2006 U.S. Dist. LEXIS 12674 (S.D. Miss. 2006).

Once someone who possesses uninsured motorist coverage knows, or reasonably should know, that the damages claimed to have been suffered exceed the limits of insurance available to the alleged tortfeasor, the cause of action against the uninsured motorist carrier has accrued, and it is at this point in time that a potential plaintiff has a legally enforceable claim against the uninsured motorist carrier. Jackson v. State Farm Mut. Auto. Ins. Co., 852 So. 2d 641, 2003 Miss. App. LEXIS 70 (Miss. Ct. App. 2003), rev'd, 880 So. 2d 336, 2004 Miss. LEXIS 1053 (Miss. 2004).

Uninsured motorist carrier's third party subrogation claim against city accrued, and one-year statute of limitations began to run, on date of accident. Coleman v. American Mfrs. Mut. Ins. Co., 930 F. Supp. 255, 1996 U.S. Dist. LEXIS 8961 (N.D. Miss. 1996).

An insured's release and discharge of an underinsured tortfeasor who caused her personal injuries operated to preclude a subsequent subrogation suit by her uninsured motorist carrier; the carrier stepped into the shoes of its subrogor/insured and acquired no rights greater than she had and, because she had released the original tortfeasor, the carrier was barred as well. St. Paul Property & Liability Ins. Co. v. Nance, 577 So. 2d 1238, 1991 Miss. LEXIS 183 (Miss. 1991).

A tortfeasor whose automobile struck a vehicle driven by an insured was an "uninsured motorist" for subrogation purposes under the Uninsured Motorist Act pursuant to § 83-11-103(c)(iii), even though the tortfeasor was "underinsured" in fact. St. Paul Property & Liability Ins. Co. v. Nance, 577 So. 2d 1238, 1991 Miss. LEXIS 183 (Miss. 1991).

Jury's award of $500 in actual damages to insured motorcyclist who was injured in rear-end collision with uninsured automobile operated by defendant meant that its contractual damages award to the insured of $50,000 against his insurer was excessive by $49,500, in view of policy provision limiting insured's recovery against insurer to amount legally recoverable from owner or operator of uninsured vehicle. Moreover, an award against an insurer of $50,000 which carried with it subrogation rights of $500 was anomalous. Thus, contractual damage award against the insurer was reduced to Employers Mut. Casualty Co. v. Tompkins, 490 So. 2d 897, 1986 Miss. LEXIS 2489 (Miss. 1986).

Accident victim's failure to sue tortfeasor within 6 months statute of limitations does not require dismissal of suit against insurer. Bailey v. State Farm Fire & Casualty Ins. Co., 621 F. Supp. 1016, 1985 U.S. Dist. LEXIS 14082 (S.D. Miss. 1985).

Phrase "legally entitled to recover" has not been interpreted to require insured to sue or obtain judgment against uninsured tortfeasor before suing insurer. Bailey v. State Farm Fire & Casualty Ins. Co., 621 F. Supp. 1016, 1985 U.S. Dist. LEXIS 14082 (S.D. Miss. 1985).

In creating underinsured motorist coverage by amendment of § 83-11-103, legislature did not intend to abrogate rights of underinsured motorist carriers to subrogation as provided in § 83-11-107 and, therefore, underinsured motorist carrier may be allowed offset for payments by underinsured tortfeasor's liability carrier. State Farm Mut. Auto. Ins. Co. v. Kuehling, 475 So. 2d 1159, 1985 Miss. LEXIS 2235 (Miss. 1985), limited, Fidelity & Guar. Underwriters v. Earnest, 699 So. 2d 585, 1997 Miss. LEXIS 384 (Miss. 1997).

Plaintiff insured was not entitled to judgment against her insurer for personal injuries she sustained in an automobile accident with an uninsured motorist where, contrary to both the policy provision precluding settlement with an uninsured motorist without the consent of the insurer and the insurer's statutory right of subrogation, defendant insurer not only did not consent to, but had no part in or knowledge of a settlement and release between the uninsured motorist and plaintiff, and where the fact of the accident was not reported to the insurer for three weeks. Joyner v. Delta Brick & Tile Co., 367 So. 2d 914, 1979 Miss. LEXIS 2142 (Miss. 1979).

An insured who was injured in an automobile accident with an uninsured motorist was entitled to full recovery of a judgment obtained against the uninsured motorist before the insurer could assert its subrogation lien. Dunnam v. State Farm Mut. Auto. Ins. Co., 366 So. 2d 668, 1979 Miss. LEXIS 2206 (Miss. 1979).

2. Illustrative cases.

Insurer of a passenger and an insured could not proceed on a claim for "equitable indemnification" against the insured to recover a sum paid to the passenger under an underinsured/uninsured motorist policy after he was struck by the insured's car; the insurer could proceed only on a claim of subrogation under Miss. Code Ann. § 83-11-107, but because the claim was barred by the statute of limitations, the insurer had no viable claim against the insured. Miss. Farm Bureau Cas. Ins. Co. v. Orme, 422 F. Supp. 2d 685, 2006 U.S. Dist. LEXIS 12674 (S.D. Miss. 2006).

RESEARCH REFERENCES

ALR.

Insured's right to bring direct action against insurer for uninsured motorist benefits. 73 A.L.R.3d 632.

Right of insured, precluded from recovering against owner or operator of uninsured motor vehicle because of governmental immunity, to recover uninsured motorist benefits. 55 A.L.R.4th 806.

Am. Jur.

7 Am. Jur. 2d, Automobile Insurance §§ 202 et seq.

CJS.

46 C.J.S., Insurance §§ 1710, 1713 et seq.

Law Reviews.

1979 Mississippi Supreme Court Review: Insurance. 50 Miss. L. J. 813.

Phillips, A Guide to Uninsured Motorist Insurance Law in Mississippi. 52 Miss. L. J. 255.

§ 83-11-109. Arbitration provisions prohibited.

No such endorsement or provisions shall contain a provision requiring arbitration of any claim arising under any such endorsement or provisions. The insured shall not be restricted or prevented in any manner from employing legal counsel or instituting or prosecuting to judgment legal proceedings, but the insured may be required to establish legal liability of the uninsured owner or operator.

HISTORY: Codes, 1942, § 8285-55; Laws, 1966, ch. 524, § 5; Laws, 1968, ch. 376, § 1, eff from and after passage (approved March 15, 1968).

Cross References — Exclusion of legal services provided under automobile liability insurance policy from provisions relating to legal expense insurance, see § 83-49-5.

Application of this section to the exemption from liability of volunteers and sports officials, see § 95-9-5.

JUDICIAL DECISIONS

1. In general.

Miss. Code Ann. § 83-11-109 reverse preempts the Federal Arbitration Act, 9 U.S.C.S. § 1 et seq., under the McCarran-Ferguson Act, 15 U.S.C.S. § 1011 et seq., because Miss. Code Ann. § 83-11-109 regulates the business of insurance; it transfers the risk, it is limited to the insurance industry, and it is an integral part of the insured-insured relationship. Therefore, an insurer's motion to compel arbitration was denied. Am. Bankers Ins. Co. v. Inman, 436 F.3d 490, 2006 U.S. App. LEXIS 1091 (5th Cir. Miss. 2006).

Another purpose forbidding compulsory arbitration was the prevention of the unjust result which might be occasioned by two separate determinations as to the legal liability of the uninsured motorist and the amount of damages for which he is liable. Logan v. Aetna Casualty & Surety Co., 309 F. Supp. 402, 1970 U.S. Dist. LEXIS 12928 (S.D. Miss. 1970).

The primary purpose of the prohibition of compulsory arbitration agreements by this section [Code 1942, § 8285-55] was to require that the legal liability of an uninsured motorist, absent an agreement by the parties, be determined in a court of law. Logan v. Aetna Casualty & Surety Co., 309 F. Supp. 402, 1970 U.S. Dist. LEXIS 12928 (S.D. Miss. 1970).

RESEARCH REFERENCES

ALR.

Right of insured, precluded from recovering against owner or operator of uninsured motor vehicle because of governmental immunity, to recover uninsured motorist benefits. 55 A.L.R.4th 806.

Uninsured and underinsured motorist coverage: enforceability of policy provision limiting appeals from arbitration. 23 A.L.R.5th 801.

Am. Jur.

7 Am. Jur. 2d, Automobile Insurance § 138.

Law Reviews.

Phillips, A Guide to Uninsured Motorist Insurance Law in Mississippi. 52 Miss. L. J. 255.

§ 83-11-111. Excess insurance coverage.

Any policy which grants the coverage required for motor vehicle liability insurance may also grant any lawful coverage in excess of, or in addition to, the coverage specified for a motor vehicle liability policy, and the excess or additional coverage shall not be subject to the provisions of this article, except as otherwise provided in this article. With respect to a policy which grants this excess or additional coverage, the term "motor vehicle liability policy" as used herein shall apply only to that part of the coverage which is required by this article.

Any binder issued pending the issuance of a motor vehicle liability policy shall be considered as fulfilling the requirements for such policy.

HISTORY: Codes, 1942, § 8285-56; Laws, 1966, ch. 524, § 6; Laws, 1979, ch. 429, § 3, eff from and after January 1, 1980.

Cross References — Application of this section to the exemption from liability of volunteers and sports officials, see § 95-9-5.

JUDICIAL DECISIONS

1. In general.

Passenger was permitted to stack the uninsured motorist (UM) benefits of other vehicles covered under the same insurance policy as the host car because Mississippi allowed insurers to include express anti-stacking provisions in insurance policy contracts, but the insurer did not include such a provision in the insurance policy. Therefore, the absence of an express prohibition on stacking allowed the passenger to stack the UM benefits of the vehicles insured under the same policy. Brewer v. Miss. Farm Bureau Cas. Ins. Co., 2021 Miss. App. LEXIS 225 (Miss. Ct. App. May 25, 2021).

Summary judgment was properly granted to two insurers because an employee's uninsured motorist coverage was insufficient to entitle him to uninsured motorist benefits; under Miss. Code Ann. §§ 83-11-101, 83-11-103, the Class II insured had no personal uninsured motorist benefits to stack with a business policy, and an umbrella policy did not count. Meyers v. Am. States Ins. Co., 914 So. 2d 669, 2005 Miss. LEXIS 322 (Miss. 2005).

Under Mississippi law, parties are free to contract for supplemental benefits as they see fit so long as uninsured motorist benefits do not exceed liability benefits and insurance policy provision for reduction of supplemental uninsured motorist benefits because of workers' compensation received by beneficiary is enforceable with regard to those benefits, although benefits may not be reduced below minimum required by statute. Section 83-11-111 provides that any coverage in excess of coverage required by that article "shall not be subject to provisions of this article" except as provided. Porter v. Shelter Gen. Ins. Co., 678 F. Supp. 151, 1988 U.S. Dist. LEXIS 1207 (S.D. Miss. 1988).

Provision in automobile liability insurance policy providing that amounts payable under uninsured motorist insurance shall be reduced by amount paid and present value of all amounts payable under any workmen's compensation law, disability benefits law or similar law cannot reduce uninsured motorist benefits below statutory minimum, however, such provision can be applied to supplemental benefits, as Miss. Code Annotated § 83-11-111 provides that any coverage in excess of coverage required by law shall not be subject to provisions of law, such that supplemental benefits may be reduced by amounts received under workmen's compensation law. Porter v. Shelter Gen. Ins. Co., 678 F. Supp. 151, 1988 U.S. Dist. LEXIS 1207 (S.D. Miss. 1988).

Automobile insurance policy provision, which excluded from uninsured motorist coverage any vehicle not insured for such coverage under the policy, excluded all uninsured motorist coverage for any vehicle not listed in the policy and not just that uninsured coverage in excess of that required by statute, and the provision was invalid. Employers Mut. Casualty Co. v. Tompkins, 490 So. 2d 897, 1986 Miss. LEXIS 2489 (Miss. 1986).

Recovery under uninsured or underinsured motorist liability insurance cannot be limited by an insurer for benefits for which a premium is paid by an insured, notwithstanding clear and unambiguous language of attempted limitation by the insurer. Thus, on a claim involving one of three insured vehicles, aggregation of coverages is permitted on two distinct theories: (1) uninsured motorist coverage contained in one policy of insurance insuring the three vehicles, and for which a separate premium was paid, can be aggregated; (2) while the language of the "limits of liability" clause of the insurance policy is clear and unambiguous as to what is intended, when read together with the declaration sheet it becomes unlear and ambiguous, inasmuch as the declaration sheet seeks to provide separate coverages for uninsured motorists on three vehicular units and charges separate premiums therefor while the "limits of liability" clause seeks to repudiate such coverage; on either theory the limitation fails and is void. Government Employees Ins. Co. v. Brown, 446 So. 2d 1002, 1984 Miss. LEXIS 1598 (Miss. 1984).

The fact that a liability policy issued to an automobile repair service and providing indemnity protection to the repair service with limits of $100,000-$300,000 limited coverage provided to customers, during use of automobiles loaned by the service to the limits fixed by the Motor Vehicle Safety Responsibility Law, did not render the policy illegal or contrary to public policy. Travelers Indem. Co. v. Chappell, 246 So. 2d 498, 1971 Miss. LEXIS 1399 (Miss. 1971).

RESEARCH REFERENCES

ALR.

Validity of exclusion in automobile insurance policy precluding recovery of no-fault benefits for injuries arising out of the ownership, maintenance, or use of an uninsured vehicle owned by an insured. 18 A.L.R.4th 632.

Combining or "stacking" uninsured motorist coverages provided in policies issued by different insurers to same insured. 21 A.L.R.4th 211.

Omnibus clause as extending automobile liability coverage to third person using car with consent of permittee of named insurer. 21 A.L.R.4th 1146.

Primary insurer's insolvency as affecting excess insurer's liability. 85 A.L.R.4th 729.

Requirement that multicoverage umbrella insurance policy offer uninsured-or underinsured-motorist coverage equal to liability limits under umbrella provisions. 52 A.L.R.5th 451.

Am. Jur.

28 Am. Jur. Proof of Facts 3d 507, Proof of Excess Insurer's Cause of Action against Primary Insurer.

Law Reviews.

Phillips, A Guide to Uninsured Motorist Insurance Law in Mississippi. 52 Miss. L. J. 255.

Comment: Uninsured motorist insurance, the commercial fleet policy, and Harris v. Magee: a modest proposal for change. 61 Miss. L. J. 171 (Spring 1991).

ARTICLE 5.

AUTOMOBILE CLUB SERVICES.

Sec.	
83-11-201.	Citation.
83-11-203.	Definitions.
83-11-205.	Additional insurance services.
83-11-207.	Security deposit or bond.
83-11-209.	Purposes and conditions of security.
83-11-211.	Members' rights against surety bond.
83-11-213.	Rights against cash deposit.
83-11-215.	Approval of name.
83-11-217.	Certificate of authority.
83-11-219.	Application for certificate.
83-11-221.	Renewal of certificate.
83-11-223.	Expiration and reinstatement of certificate.
83-11-225.	Grounds for revocation of certificate.
83-11-227.	Solicitation for club not having certificate of authority.
83-11-229.	Service contracts.
83-11-231.	Mandatory information and provisions of contract.
83-11-233.	Misrepresentation.
83-11-235.	Effect of non-complying contract.
83-11-237.	Notice of appointment of sales agent.
83-11-239.	Revocation of agent's registration.
83-11-241.	Hearing on revocation.
83-11-243.	Financial statements.
83-11-245.	Violations.
83-11-247.	Monies to be deposited.

§ 83-11-201. Citation.

This article shall be known and cited as the "Automobile Club Services Law."

HISTORY: Codes, 1942, § 5670.9-01; Laws, 1971, ch. 467, § 1, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.

7 Am. Jur. 2d, Automobiles and Highway Traffic § 49.

Practice References.

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-11-203. Definitions.

As used in this article:

(a) "Automobile club" shall mean any person who, in consideration of dues, assessments, or periodic payments of money, promises its members or subscribers to assist them in matters relating to travel and the operation, use, and maintenance of an automobile in the supply of features or services which may include:

(1) such services as community traffic safety services, travel and touring service, theft or reward service, map service, towing service, emergency road service, and legal fee reimbursement service in the defense of traffic offenses, none of which enumerated features or services, if provided by the automobile club itself, shall be subject to the insurance laws of this state;

(2) the purchase of accidental injury and death benefits insurance coverage and the purchase of bail bond coverage, as provided by applicable statutes, by an insurance company authorized to do business in Mississippi; and

(3) such other features or services not deemed by the commissioner to constitute the business of insurance.

Provided, however, the definition of an automobile club shall not include persons, associations, or corporations whose services are provided predominantly on a reimbursable basis. Such operations shall constitute insurance and be subject to the insurance laws of Mississippi.

(b) "Commissioner" means the commissioner of insurance of the State of Mississippi.

(c) "Club agent" is a person, other than the automobile club itself, who acts or aids in any manner in the solicitation, delivery, or negotiation of any service contract, or of the renewal or continuance thereof. This, however, shall not include any person performing only work of a clerical nature in the office of the automobile club.

(d) "Service contract" means an agreement whereby an automobile club, for a consideration, promises to render, furnish, procure, or reimburse club members specified services.

(e) "Person" means any individual person, firm, company, corporation, partnership, or association.

(f) "Insurance service" means the selling or making available individual or group insurance policies or certificates other than service contracts as a result of membership in or affiliation with an automobile club; such policies, if sold or made available, shall be issued only by an insurance company duly authorized to do business in Mississippi.

HISTORY: Codes, 1942, § 5670.9-02; Laws, 1971, ch. 467, § 2, eff from and after September 1, 1971.

Cross References — Guaranteed arrest bond certificate in lieu of cash bail for certain traffic violations, see § 63-9-27.

RESEARCH REFERENCES

Am. Jur.
7 Am. Jur. 2d, Automobiles and Highway Traffic § 49.

§ 83-11-205. Additional insurance services.

The commissioner may, upon the application of an automobile club, allow such automobile club to provide specific insurance services not enumerated in section 83-11-203(a)(2).

HISTORY: Codes, 1942, § 5670.9-03; Laws, 1971, ch. 467, § 3, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-11-207. Security deposit or bond.

No automobile club shall render or agree to render service without first depositing and thereafter continuously maintaining security in one (1) of the following forms with the commissioner:

(a) The sum of Fifteen Thousand Dollars ($15,000.00) in cash or Fifteen Thousand Dollars ($15,000.00) surety bond by a surety company authorized to do business in Mississippi, or Fifteen Thousand Dollars ($15,000.00) in securities of a type approved by the commissioner and qualified for legal investment by an insurance company authorized to do business in Mississippi.

(b) If any security deposited with the commissioner shall become impaired and shall not be restored within thirty (30) days after written demand by the commissioner, the commissioner shall revoke the certificate of authority of the automobile club or, in the alternative, the commissioner may require such additional security deposit as in his discretion he shall deem necessary to restore adequate securities for the automobile club deposit.

HISTORY: Codes, 1942, § 5670.9-04; Laws, 1971, ch. 467, § 4, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
7A Am. Jur. 2d, Automobile and Highway Traffic § 50.

§ 83-11-209. Purposes and conditions of security.

The security required to be filed by this article shall be for the protection, use, and benefit of any club member, shall be subject to the following conditions, and, if a surety bond, shall be so expressly conditioned that:

(a) The club will faithfully furnish and render to club members any and all of the automobile club services sold or offered for sale by it, and

(b) The club will pay any fines, fees, or penalties imposed upon it pursuant to the provisions of this article.

HISTORY: Codes, 1942, § 5670.9-05; Laws, 1971, ch. 467, § 5, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 72.

CJS.
44 C.J.S., Insurance §§ 121-123.

§ 83-11-211. Members' rights against surety bond.

If a surety bond is filed, any applicant defrauded or injured by any wrongful act, misrepresentation, or failure on the part of the automobile club with respect to the selling or rendering of any of its services may bring suit on such bond in his own name; but the aggregate liability of the surety for all such suits shall, in no event, exceed the sum of such bond.

HISTORY: Codes, 1942, § 5670.9-06; Laws, 1971, ch. 467, § 6, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 72.

CJS.
44 C.J.S., Insurance §§ 121-123.

§ 83-11-213. Rights against cash deposit.

A deposit of cash or securities, in lieu of a surety bond, shall be subject to the conditions applying to the bond and to execution on judgments against the club.

HISTORY: Codes, 1942, § 5670.9-07; Laws, 1971, ch. 467, § 7, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 72.

CJS.
44 C.J.S., Insurance §§ 121-123.

§ 83-11-215. Approval of name.

The name of the automobile club shall be submitted to the commissioner for approval pursuant to Section 83-11-219 before the commencement of business under the provisions of this article. The commissioner shall reject any name so submitted when the proposed name is deceptively similar to that of any other automobile club or other corporation licensed or qualified to do business in this state.

HISTORY: Codes, 1942, § 5670.9-08; Laws, 1971, ch. 467, § 8, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-11-217. Certificate of authority.

No person shall render or agree to render automobile club service in this state without first obtaining from the commissioner a certificate of authority so to act.

HISTORY: Codes, 1942, § 5670.9-09; Laws, 1971, ch. 467, § 9, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
7 Am. Jur. 2d, Automobiles and Highway Traffic § 49.

CJS.
44 C.J.S., Insurance §§ 105-115.

§ 83-11-219. Application for certificate.

An application for an original certificate of authority as an automobile club shall be made to the commissioner in such form and detail as the commissioner shall prescribe and shall have annexed thereto:

(a) A copy of its charter as amended, certified, if a foreign company, by the proper public officer of the state or country of domicile;

(b) A copy of its bylaws, if any, certified by its proper officer;

(c) A statement of its financial condition, management, and affairs;

(d) A copy of each form of service agreement, contract, and service brochure it proposes to use in this state;

(e) If a foreign company, a certificate from the proper public official from its state or country of domicile showing that it is duly organized and is authorized to transact the type of automobile club service which it proposes to transact in Mississippi;

(f) Other documents or stipulations as the commissioner may reasonably require to evidence compliance with the provisions of the laws of the State of Mississippi;

(g) A certificate issued by the secretary of state that it has qualified to do business as a corporation in this state, and that it has appointed the commissioner as its attorney to receive service of legal process.

The application shall be accompanied by a fee of One Hundred Dollars ($100.00), payable to the State of Mississippi.

HISTORY: Codes, 1942, § 5670.9-10; Laws, 1971, ch. 467, § 10, eff from and after September 1, 1971.

Cross References — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

RESEARCH REFERENCES

Am. Jur.
7 Am. Jur. 2d, Automobiles and Highway Traffic § 49.

CJS.
44 C.J.S., Insurance §§ 105-115, 129, 130.

§ 83-11-221. Renewal of certificate.

A certificate of authority duly issued by the commissioner shall be evidence of an automobile club's authority to transact the business of furnishing automobile club service in this state.

A certificate of authority shall continue in force as long as the automobile club is entitled thereto under this article and until suspended or revoked by the commissioner, or terminated at the request of the automobile club; subject, however, to renewal of the certificate by the automobile club each year by:

(a) Payment prior to March 1 of each year, following that in which its original certificate is filed, of a fee of Twenty-five Dollars ($25.00), and

(b) due filing by the automobile club of its annual financial statement for the calendar year preceding, as required under Section 83-11-243.

HISTORY: Codes, 1942, § 5670.9-11; Laws, 1971, § 11, eff from and after September 1, 1971.

Cross References — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 68, 70.

CJS.
44 C.J.S., Insurance §§ 96, 118-120, 131, 132.

§ 83-11-223. Expiration and reinstatement of certificate.

Certificates of authority shall expire as of midnight on March 31 unless renewed. The commissioner shall promptly notify the automobile club of the occurrence of any failure resulting in impending expiration of its certificate of authority.

The commissioner may in his discretion upon the automobile club's request, made within three (3) months after expiration, reinstate and renew a certificate of authority which the automobile club had inadvertently permitted to expire, after the automobile club has fully cured all of its failures which resulted in expiration, and upon payment by the automobile club of a fee for reinstatement of Fifty Dollars ($50.00). Otherwise, the automobile club shall be granted another certificate of authority only after filing application therefor and meeting all other requirements as for an original certificate of authority in this state.

HISTORY: Codes, 1942, § 5670.9-12; Laws, 1971, ch. 467, § 12, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
7 Am. Jur. 2d, Automobiles and Highway Traffic § 49.

CJS.
44 C.J.S., Insurance § 105-115.

§ 83-11-225. Grounds for revocation of certificate.

The commissioner may revoke, suspend, or refuse to continue the certificate of authority of an automobile club whenever, after a hearing and for cause shown, he determines that any of the following circumstances exist:

(a) The club has violated any provision of this article;

(b) It is found by the commissioner to be in such financial condition that its further transaction of automobile club service in this state would be hazardous to its members and the automobile club service-buying public in this state, or that it is insolvent;

(c) It refuses to remove, discharge, or terminate its relationship with a director or officer who has been convicted of any crime involving fraud, dishonesty, or like moral turpitude;

(d) It customarily or in the regular course of business compels claimants under its service contracts either to accept less than the amount due them or fewer services, or to bring suit against it to secure full payment of the amount of all services due;

(e) It conducts its business outside this state in such manner as unjustly to discriminate against or prejudice the interests of the people of this state;

(f) It is affiliated with and is under the same general management or interlocking directorate or ownership as another automobile club which transacts business in this state which does not have a certificate of authority therefor;

(g) It exceeds its charter powers of its certificate of authority;

(h) It refuses to be examined, or if its directors, managing officers, employees, or representatives refuse to submit to examination by the commissioner when required by him, or refuses to perform any legal obligation relative to the examination, the time and place of the examination to be specified by the commissioner.

HISTORY: Codes, 1942, § 5670.9-13; Laws, 1971, ch. 467, § 13, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance § 124.

§ 83-11-227. Solicitation for club not having certificate of authority.

No person shall solicit or aid in the solicitation of another person to purchase a service contract or membership issued by a club not having a certificate of authority procured pursuant to this article.

HISTORY: Codes, 1942, § 5670.9-16; Laws, 1971, ch. 467, § 16, eff from and after September 1, 1971.

§ 83-11-229. Service contracts.

Automobile clubs shall be required to execute service contracts with their members. No service contract shall be executed, issued, or delivered in this state until the form thereof has been approved in writing by the commissioner.

A service contract may be in the form of a written agreement between the automobile club and a member, or it may consist of a completed application, a membership card, and a written description of services to be rendered by the automobile club.

HISTORY: Codes, 1942, § 5670.9-14; Laws, 1971, ch. 467, § 14, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

CJS.
44 C.J.S., Insurance § 392.

§ 83-11-231. Mandatory information and provisions of contract.

No service contract shall be executed, issued, or delivered in the state unless it contains the following:

(a) The exact corporate or other name of the club.

(b) The exact location of its home office and of its usual place of business in the state, giving street number and city.

(c) A provision that the contract may be canceled at any time by giving written notice thereof by either the club or the holder, and that the holder will, if the dues or membership fee has been paid thereupon, be entitled to a refund of the unused portion of the consideration paid for such contract, calculated on a pro rata basis over the period of the contract, without any deductions, provided that the automobile club may make a reasonable minimum charge.

(d) A provision plainly specifying: the services promised, that the holder will not be required to pay any sum in addition to the amount specified in the contract for any services thus specified, the territory wherein such services are to be rendered, the date when such service will commence, and a statement in not less than fourteen (14) point modern type at the head of said contract stating, "This is not an insurance contract."

HISTORY: Codes, 1942, § 5670.9-15; Laws, 1971, ch. 467, § 15, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

CJS.
44 C.J.S., Insurance § 392.

§ 83-11-233. Misrepresentation.

No automobile club or officer or agent thereof shall in any manner misrepresent the terms, benefits, or privileges of any service contract or membership issued or to be issued by it.

HISTORY: Codes, 1942, § 5670.9-17; Laws, 1971, ch. 467, § 17, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 74, 78.

§ 83-11-235. Effect of non-complying contract.

Any service contract or membership made, issued, or delivered contrary to any provision of this article shall, nevertheless, be valid and binding on the club.

HISTORY: Codes, 1942, § 5670.9-18; Laws, 1971, ch. 467, § 18, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

CJS.
44 C.J.S., Insurance § 392.

§ 83-11-237. Notice of appointment of sales agent.

(1) An automobile club operating in this state pursuant to a certificate of authority issued hereunder shall, within thirty (30) days of the date of appointment, file with the commissioner a notice of appointment of a club agent by an automobile club to sell memberships in the automobile club to the public. This notification shall be upon such form as the commissioner may prescribe, shall contain the name, address, age, sex, and social security number of such club agent, and also contain proof satisfactory to the commissioner that such applicant is of good reputation and that he has received training from the club or is otherwise qualified in the field of automobile club service contracts and the laws of this state pertaining thereto. Upon termination of any club agent's appointment by an automobile club, such automobile club shall, within thirty (30) days thereafter, notify the commissioner of such termination.

(2) The registration fee for club agents shall be Five Dollars ($5.00) annually, and such registration shall be renewable on April 1 of each year unless sooner revoked or suspended.

HISTORY: Codes, 1942, § 5670.9-19; Laws, 1971, ch. 467, § 19, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 75.

CJS.
44 C.J.S., Insurance § 138.

§ 83-11-239. Revocation of agent's registration.

The commissioner may suspend, revoke, or refuse to renew any club agent's registration for any of the following causes:

(a) If the club agent violated any of the provisions or requirements of this article;

(b) If the club agent has misappropriated, converted to his own use, or has illegally withheld monies required to be held in the fiduciary capacity;

(c) If the club agent has materially misrepresented the terms or effect of any contract or has engaged in any fraudulent transaction;

(d) If in the conduct of his affairs he has shown himself to be incompetent, untrustworthy, or a source of injury and loss to the automobile club service-buying public;

(e) If the club agent has been convicted after registration of a crime involving moral turpitude.

HISTORY: Codes, 1942, § 5670.9-20; Laws, 1971, ch. 467, § 20, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 77.

CJS.
44 C.J.S., Insurance § 138.

§ 83-11-241. Hearing on revocation.

No club agent's registration shall be suspended or revoked by the commissioner without providing an opportunity to be heard and to produce evidence in his own behalf.

HISTORY: Codes, 1942, § 5670.9-21; Laws, 1971, ch. 467, § 21, eff from and after September 1, 1971.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 77.

CJS.
44 C.J.S., Insurance § 138.

§ 83-11-243. Financial statements.

Each authorized automobile club shall annually, before March 1, file with the commissioner a true statement of its financial condition, transactions, and affairs as of December 31 preceding. The statement shall contain such information as may be reasonably required by the commissioner, and shall be verified by the oaths of at least two (2) of the automobile club's principal officers.

The commissioner may suspend or revoke the certificate of authority of any automobile club failing to file its annual statement when due or during any extension of time therefor which the commissioner, for good cause, may grant.

HISTORY: Codes, 1942, § 5670.9-22; Laws, 1971, ch. 467, § 22, eff from and after September 1, 1971.

Cross References — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.
14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.
44 C.J.S., Insurance § 96.

§ 83-11-245. Violations.

Any person violating any of the provisions of this article shall be guilty of a misdemeanor.

HISTORY: Codes, 1942, § 5670.9-23; Laws, 1971, ch. 467, § 23, eff from and after September 1, 1971.

Cross References — Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

§ 83-11-247. Monies to be deposited.

All monies collected by the commissioner under any provisions of this article shall be deposited in the general treasury.

HISTORY: Codes, 1942, § 5670.9-24; Laws, 1971, ch. 467, § 24, eff from and after September 1, 1971.

ARTICLE 7.

TOWING AND STORAGE OF DISABLED VEHICLES.

Sec.

83-11-301. Recovery of towing and storage charges from insurer.

§ 83-11-301. Recovery of towing and storage charges from insurer.

(1) An automobile insurance policy shall not be construed to allow an insurer to assume or accede to the legal title of a motor vehicle without assuming credit obligations of the insured owner of the motor vehicle for reasonable and customary charges for towing and storage services associated with the incident from which the insurance coverage arises.

(2) An insurer which has succeeded to the title of a motor vehicle is not authorized to abandon such vehicle to a towing or storage service without consent of the provider of such service.

(3)(a) A debt incurred by or on behalf of a named insured for towing or storage services may be collected from an insurer which succeeds to the legal title of the motor vehicle covered under the policy for physical damage, property damage or uninsured motorist coverage.

(b) An insurer may be authorized by the provisions of an automobile insurance policy to act for a named insured in any matter regarding the towing and storage of a covered disabled vehicle.

HISTORY: Laws, 1988, ch. 403, eff from and after July 1, 1988.

RESEARCH REFERENCES

Practice References.
New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

ARTICLE 9.

REPAIRS TO DAMAGED VEHICLES.

Sec.
83-11-501. Requirement that repairs be made at particular shop prohibited; insurer's payment of lowest fair amount in geographic or trade area.
83-11-503. Advertisement to pay insured's deductibles prohibited.

§ 83-11-501. Requirement that repairs be made at particular shop prohibited; insurer's payment of lowest fair amount in geographic or trade area.

No insurer may require as a condition of payment of a claim that repairs to a damaged vehicle, including glass repairs or replacements, must be made by a particular contractor or motor vehicle repair shop; provided, however, the most an insurer shall be required to pay for the repair of the vehicle or repair or replacement of the glass is the lowest amount that such vehicle or glass could be properly and fairly repaired or replaced by a contractor or repair shop within a reasonable geographical or trade area of the insured.

HISTORY: Laws, 1989, ch. 415, § 1; Laws, 1992, ch. 528, § 1, eff from and after July 1, 1992.

RESEARCH REFERENCES

Practice References.
New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

JUDICIAL DECISIONS

1. Priority Repair Option program.

District court properly dismissed body shops' claims under this statute because body shops did not allege that insurance companies conditioned payment of claim on repairs being made by particular shop. Auto. Alignment & Body Serv. v. State Farm Mut. Auto. Ins. Co., 953 F.3d 707, 2020 U.S. App. LEXIS 7044 (11th Cir. Fla. 2020).

The defendant insurance company was entitled to summary judgment in an action alleging a violation of the statute where the plaintiff presented no evidence suggesting that the defendant or any of its agents had conditioned payment of a claim upon the utilization of the body shops participating in its priority repair option program and, to the contrary, the plaintiff's own witnesses attested to the fact that while the defendant's agents may have recommended certain participating body shops, the defendant did not condition payment upon having those shops make the repairs to the insured's vehicles. Addison v. Allstate Ins. Co., 97 F. Supp. 2d 771, 2000 U.S. Dist. LEXIS 7029 (S.D. Miss. 2000).

A "Priority Repair Option" program, whereby the defendant insurance company pre-approved certain automobile body repair shops to perform repairs for its insureds did not violate this section where the plaintiff presented absolutely no evidence that the insurance company, or any of its agents, through the program, required its insureds to have repairs done at particular body shops. Christmon v. Allstate Ins. Co., 82 F. Supp. 2d 612, 2000 U.S. Dist. LEXIS 1185 (S.D. Miss. 2000).

§ 83-11-503. Advertisement to pay insured's deductibles prohibited.

No person selling or engaged in the sale of automobile replacement glass shall advertise to pay all or part of an insured's deductible under an insurance policy.

HISTORY: Laws, 1992, ch. 528, § 2, eff from and after July 1, 1992.

RESEARCH REFERENCES

ALR.

Practices forbidden by state deceptive trade practice and consumer protection acts. 89 A.L.R.3d 449.

Automobile repairman's duty to provide customer with information, estimates, or replaced parts, under automobile repair consumer protection act. 25 A.L.R.4th 506.

ARTICLE 11.

PAYMENT OF CLAIMS.

Sec.	
83-11-551.	Addition of name of business repairing automobile or lienholder as payee on check; obtaining title where there is total loss settlement; release of vehicle by auction firm or automotive dismantler to owner or lienholder if insurer does not take ownership; lien-free salvage certificate of title.

§ 83-11-551. Addition of name of business repairing automobile or lienholder as payee on check; obtaining title where there is total loss settlement; release of vehicle by auction firm or automotive dismantler to owner or lienholder if insurer does not take ownership; lien-free salvage certificate of title.

(1) In cases in which there is not a total loss, when there are one or more lienholders shown in the policy or confirmed in writing by the insured before the loss, an insurer paying a claim under automobile physical damage

coverage or automobile collision coverage, as such terms are defined in Section 83-11-1, shall add as a payee on the check, in addition to the name of the insured, the name of the business or other entity repairing the automobile or the name of the lienholder or lienholders.

(2) In cases of a total loss, when there are one or more lienholders (a) shown in the policy, (b) confirmed in writing by the insured before the loss, or (c) shown on the vehicle title recorded with the Mississippi Department of Revenue, an insurer paying a claim under automobile physical damage coverage or automobile collision coverage, as such terms are defined in Section 83-11-1, shall add as a payee on the check, in addition to the name of the insured, the name of the lienholder or lienholders.

(3) If the insured disputes the existence of any lien, it is the insured's responsibility to have the liens released. When payment is made to a lienholder, the lienholder shall pay any balance owed to the debtor within thirty (30) days after receipt of the check. However, in the case of a total loss, the insurer may issue separate checks to the lienholder and to the insured for the amount of each party's financial interest in the vehicle. This section shall not apply to the repair or replacement of glass in the vehicle.

(4) If an insurance company makes a total loss settlement on a motor vehicle, the owner or lienholder of the motor vehicle shall forward the properly endorsed certificate of title to the insurance company within fifteen (15) days after receipt of the settlement funds.

(5)(a) If an insurance company is unable to obtain the properly endorsed certificate of title within fifteen (15) days after disbursing a total loss settlement payment for a motor vehicle that does not have a lien or encumbrance, the insurance company or its agent may request the Department of Revenue to issue a salvage certificate of title or a parts-only certificate of title for the vehicle.

(b) The request under paragraph (a) of this subsection shall:

(i) Be submitted on each form required by and provided by the Department of Revenue which may be completed by the insurance company or its agent;

(ii) Attest on the form required in subparagraph (i) that the insurance company or its agent has made at least two (2) attempts to obtain the certificate of title;

(iii) Include any fees applicable to the issuance of a salvage certificate of title or a parts-only certificate of title; and

(iv) Be signed under penalty of perjury.

(c) Notice under paragraph (b) of this subsection shall be provided concurrently with the payment of the claim or by either first-class mail to the last-known address or other commercially available delivery service or electronic means, including electronic mail or posting on an electronic network or site that is accessible to the vehicle owner via the internet by using a mobile application, computer, mobile device, tablet or any other electronic device.

(6)(a) If an insurance company or its agent is unable to obtain the properly endorsed certificate of title within fifteen (15) days after disbursing a total loss settlement payment for a motor vehicle that has a lien or encumbrance, the insurance company or its agent shall attest to the Department of Revenue that the lienholder's interest was protected in the total loss indemnity payment for the claim.

(b) The documentation under paragraph (a) of this subsection shall be:

(i) Submitted with a request for a salvage certificate of title or a parts-only certificate of title for the vehicle; and

(ii) The requirements under subsection (5)(b) of this section.

(7) Upon receipt of a properly endorsed certificate of title or a properly executed request under subsection (5) of this section, the Department of Revenue shall issue a salvage certificate of title or a parts-only certificate of title for the vehicle in the name of the insurance company.

(8) The Department of Revenue may promulgate rules, regulations and forms for the administration of subsections (4) through (6) of this section.

(9)(a) If an insurer requests an auction firm, the primary business of which is the sale of salvage vehicles on behalf of insurers, or an automotive dismantler as defined in Section 27-19-303(h), to take possession of a vehicle that is the subject of an insurance claim and subsequently the insurer does not take ownership of the vehicle, the insurer may direct the auction firm or the automotive dismantler to release the vehicle to the owner or lienholder. The insurer shall provide the auction firm or the automotive dismantler a release statement authorizing the auction firm or the automotive dismantler to release the vehicle to the vehicle's owner or lienholder.

(b) Upon receiving a release statement from an insurer, the auction firm or the automotive dismantler shall send notice to the owner and any lienholder of the vehicle informing the owner or lienholder that the vehicle is available for pick up. The notice shall include an invoice for any outstanding charges owed to the auction firm or the automotive dismantler. The notice shall inform the owner and any lienholder that the owner or lienholder has thirty (30) days from the date of the notice, and upon payment of applicable charges owed to the auction firm or the automotive dismantler, to pick up the vehicle from the auction firm or the automotive dismantler. Notice under this subsection must be sent by certified mail to the last-known address or by another commercially available delivery service providing proof of delivery to the address on record with the department.

(c) If the owner or any lienholder of the vehicle does not pick up the vehicle within thirty (30) days after notice was sent to the owner and any lienholder in accordance with this subsection, the vehicle shall be considered abandoned, the vehicle's certificate of title is deemed to be assigned to the auction firm or the automotive dismantler, and the auction firm or the automotive dismantler, without surrendering the certificate of title, may request on a form provided by the department that the department shall issue a lien-free salvage certificate of title or a parts-only certificate of title for the vehicle. The request shall be accompanied by a copy of the notice required by this subsection and proof of delivery of the notice required by this subsection sent to the owner and any lienholder. Notwithstanding any outstanding liens against the vehicle, the department shall issue a lien-free salvage certificate of title or a parts-only certificate of title for the vehicle to the auction firm in possession of the vehicle.

HISTORY: Laws, 2007, ch. 594, § 1; Laws, 2009, ch. 461, § 1; Laws, 2012, ch. 392, § 1; Laws, 2014, ch. 435, § 1; Laws, 2017, ch. 318, § 1, eff from and after July 1, 2017; Laws, 2020, ch. 306, § 1, eff from and after July 1, 2020; Laws, 2021, ch. 366, § 1, eff from and after July 1, 2021.

Editor's Notes — Laws of 2007, ch. 594, § 2 provides as follows:

"SECTION 2. Section 1 of this act shall be codified within Chapter 11, Title 83 of the Mississippi Code of 1972."

Amendment Notes — The 2021 amendment, in (5), substituted "fifteen (15) days" for "thirty (30) days" in (a), added "which may be completed by the insurance company or its agent" in (b)(i), rewrote (b)(ii), which read: "Document that the insurance company has made at least two (2) written attempts to obtain the certificate of title and include the documentation with the request," and added (c); in (6), inserted "or its agent," substituted "fifteen (15) days" for "thirty (30) days," "attest" for "submit documentation," and deleted "from the claims file" following "Department of Revenue" and "establishes" preceding "the lienholder's interest"; and added (9).

RESEARCH REFERENCES

Practice References.

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

CHAPTER 13.

FIRE INSURANCE

Sec.

83-13-1. Reinsurance.
83-13-3. Liabilities and reserves.
83-13-5. Amount of insurance.
83-13-7. Mortgagees protected in order of priority.
83-13-9. Mortgage clause.
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83-13-11. Conditions to be stated in full.
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83-13-15. Repealed.
83-13-17. Industrial fire insurance policies.
83-13-19. Unauthorized companies denied access to courts.
83-13-21. Information required of insurers in case of fire losses.
83-13-23. Insurer required to pay volunteer fire department for protecting property insured by insurer.
83-13-25. Form to be used by fire departments for minimum payments from insurers.

§ 83-13-1. Reinsurance.

Every insurer authorized to issue policies in this state may reinsure in any other insurer any part or all of any risk or risks assumed by it; but such reinsurance, unless effected with an insurer authorized to issue policies in this state and subject to the payment of the tax thereon, shall not operate to permit any reduction of taxes through reinsurance effected with an insurer not authorized to issue policies in this state.

HISTORY: Codes, 1892, § 2341; 1906, § 2607; Hemingway's 1917, § 5070; 1930, § 5181; 1942, § 5691.

Cross References — Annual returns of reinsurance contracts, see § 83-5-57.

RESEARCH REFERENCES

ALR.

Recovery under fire insurance policy for damage to party wall. 13 A.L.R.2d 619.

Applicability of value policy statute to partial fire loss. 36 A.L.R.2d 619.

Who May Enforce Liability of Reinsurer. 87 A.L.R.6th 319.

Am. Jur.

44A Am. Jur. 2d, Insurance §§ 1842 et seq.

14A Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 1081 (complaint, petition, or declaration for recovery on reinsurance policy by primary insurer against reinsurer).

CJS.

46 C.J.S., Insurance §§ 1720 et seq.

Practice References.

Business Insurance Law and Practice Guide, (Matthew Bender).

Business Law Monographs, Volume IN2--Casualty and Liability Insurance (Matthew Bender elite Products).

Insuring Real Property (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-13-3. Liabilities and reserves.

To determine the liability upon the contracts of an insurance company, other than life and real estate title insurance, and thence the amount such company shall hold as a reserve for reinsurance, the commissioner shall take the actual unearned portion of the premiums written in its policies.

HISTORY: Codes, 1906, § 2613; Hemingway's 1917, § 5076; 1930, § 5182; 1942, § 5692.

Cross References — Reserve liabilities of life insurance companies, see §§ 83-7-21 et seq.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 71.	44 C.J.S., Insurance §§ 159-161, 174, 175.

§ 83-13-5. Amount of insurance.

No insurance company shall knowingly issue any fire insurance policy upon property within this state for an amount which, together with any existing insurance thereon, exceeds a fair value of the property, nor for a longer term than five (5) years. When buildings and structures are insured against loss by fire and, situated within this state, are totally destroyed by fire, the company shall not be permitted to deny that the buildings or structures insured were worth at the time of the issuance of the policy the full value upon which the insurance is calculated, and the measure of damages shall be the amount for which the buildings and structures were insured. No insurance company or agent thereof shall be permitted to attach a three-quarter value clause to insurance of this kind, and any fire insurance company or agent thereof who violates this section shall be guilty of a misdemeanor and shall, upon conviction, be fined not less than Two Hundred Dollars ($200.00) nor more than One Thousand Dollars ($1,000.00) for each offense.

HISTORY: Codes, 1892, § 2337; 1906, § 2592; Hemingway's 1917, § 5056; 1930, § 5183; 1942, § 5693; Laws, 1912, ch. 224; Laws, 1936, ch. 206.

Cross References — Prohibition against disclosure of expiration date of insurance on mortgaged property, see § 83-13-10.

Personal liability of agent, see § 83-17-3.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Applicability.
3. Policy provisions inconsistent with statute.
4. When loss deemed total.
5. Partial loss.
6. Concurrent insurance.
7. Insurance of personal property.
8. Waiver of benefit of statute.
9. Proof of value.

1. In general.

Mere fact that insurance company rejected claims under provisions of its policy and defendant sued and lost does not justify imposition of punitive damages, where insurance company had arguable reason not to pay claim; term legitimate or arguable reason is nothing more than expression indicating act or acts of alleged tortfeasor did not rise to heightened level of independent tort. Western Fire Ins. Co. v. Copeland, 651 F. Supp. 1051, 1987 U.S. Dist. LEXIS 3027 (S.D. Miss.), aff'd, 824 F.2d 970, 1987 U.S. App. LEXIS 9707 (5th Cir. Miss. 1987).

Where, in an action by insureds against their insurer to recover under the policy for damage to plaintiffs' home and contents during a hurricane and there was a justifiable dispute as to the amount of the loss, the insureds were not entitled to interest until the amount of the claim was made certain or liquidated. Commercial Union Ins. Co. v. Byrne, 248 So. 2d 777, 1971 Miss. LEXIS 1480 (Miss. 1971).

Where fire, rather than an explosion, was the dominant and efficient cause of the total destruction of property, the valued policy provisions of this section [Code 1942, § 5693] are applicable. Great American Ins. Co. v. Smith, 252 Miss. 62, 172 So. 2d 558, 1965 Miss. LEXIS 1162 (Miss. 1965).

The local agent of an insurance company furnished with blank forms to be filled out, countersigned and issued by him, has all the powers of the general agent when issuing policies, and can waive any of the policy provisions. American Cent. Ins. Co. v. Meredith, 228 Miss. 402, 87 So. 2d 871, 1956 Miss. LEXIS 527 (Miss. 1956).

Where building was a total loss as result of fire, and appraisers' determination of loss was ineffective because not based on value of property as stated in policy, interest on claim against insurer accrued from date of loss and not from sixty days after determination. Yorkshire Ins. Co. v. Brewer, 175 Miss. 538, 166 So. 361, 1936 Miss. LEXIS 17 (Miss. 1936).

Lessee has insurable interest, and may recover full amount of fire policy issued to him on leased premises. Mississippi Fire Ins. Co. v. Planters' Bank of Tunica, 138 Miss. 275, 103 So. 84, 1925 Miss. LEXIS 50 (Miss. 1925).

Valued policy law held not violative of equal protection clause nor due process clause of the Const. Mississippi Fire Ins. Co. v. Planters' Bank of Tunica, 138 Miss. 275, 103 So. 84, 1925 Miss. LEXIS 50 (Miss. 1925).

2. Applicability.

Insureds' claim that an insurer violated Mississippi's Valued Policy statute, Miss. Code Ann. § 83-13-5, with regard to the insureds' homeowners policy and flood insurance policy failed because that statute applied only to fire insurance policies. Remel v. State Farm Fire & Cas. Co., 2009 U.S. Dist. LEXIS 15616 (S.D. Miss. Feb. 25, 2009).

3. Policy provisions inconsistent with statute.

Personal property, such as contents of building, does not come within valued policy statute; valued policy statute has initial application to mobile homes; operation of valued policy statutes sets value of mobile homes for purpose of recovery at face amount of insurance, and proof of loss as to value of total destroyed property is not essential. Foremost Ins. Co. v. Lowery, 617 F. Supp. 521, 1985 U.S. Dist. LEXIS 16544 (S.D. Miss. 1985).

Where the loss by fire of a dwelling was total, no appraisal was required, any provision of the policy requiring an appraisal being written out by this statute, and a suit for the face amount of the policy was not barred by the failure of the insured, to select a competent and disinterested appraiser as requested by the insurer's attorney, pursuant to the provisions of the policy. Maryland Casualty Co. v. Legg, 247 So. 2d 812, 1971 Miss. LEXIS 1455 (Miss. 1971).

Provision in policy that insurer shall not be liable beyond actual value destroyed by fire, for loss caused by ordinance or law regulating construction or repair of buildings, is void. Palatine Ins. Co. v. Nunn, 99 Miss. 493, 55 So. 44, 1911 Miss. LEXIS 218 (Miss. 1911).

Co-insurance clauses, three-quarter clauses, and other like clauses in fire insurance policies must yield to the statute. Hartford Fire Ins. Co. v. Schlenker, 80 Miss. 667, 32 So. 155, 1902 Miss. LEXIS 303 (Miss. 1902).

The three-quarter clause in a policy of fire insurance under this section [Code 1942, § 5693] is nugatory. Western Assurance Co. v. Phelps, 77 Miss. 625, 27 So. 745, 1900 Miss. LEXIS 31 (Miss. 1900).

The section [Code 1942, § 5693] supervenes all policies and writes out of them all stipulations inconsistent with itself. Western Assurance Co. v. Phelps, 77 Miss. 625, 27 So. 745, 1900 Miss. LEXIS 31 (Miss. 1900).

4. When loss deemed total.

In order for there to be only a "partial loss" within the terms of the valued policy statute, there must be a substantial, usable remnant of the building surviving and such surviving part must be susceptible to reasonable repairs and reconstruction, and where evidence sustained a finding that two walls of a dwelling were burnt down, the roof was damaged, all windows were broken out, and there was smoke and water damage throughout the structure, a jury was justified in concluding that the house was "totally destroyed" by fire within the meaning of the statute. Home Ins. Co. v. Greene, 229 So. 2d 576, 1969 Miss. LEXIS 1252 (Miss. 1969).

Building held total loss where, though only partly burned, it is rendered unfit for purpose constructed and an ordinance or law prohibits reconstruction. Palatine Ins. Co. v. Nunn, 99 Miss. 493, 55 So. 44, 1911 Miss. LEXIS 218 (Miss. 1911).

5. Partial loss.

In order for there to be only a "partial loss" within the terms of the valued policy statute, there must be a substantial, usable remnant of the building surviving and such surviving part must be susceptible to reasonable repairs and reconstruction, and where evidence sustained a finding that two walls of a dwelling were burnt down, the roof was damaged, all windows were broken out, and there was smoke and water damage throughout the structure, a jury was justified in concluding that the house was "totally destroyed" by fire within the meaning of the statute. Home Ins. Co. v. Greene, 229 So. 2d 576, 1969 Miss. LEXIS 1252 (Miss. 1969).

Statute providing that where property is totally destroyed insurer could not deny that property at time of issuing policy was worth full value upon which insurance was calculated, held not to prohibit policy agreements for appraisement of a partial loss. Franklin Fire Ins. Co. v. Brewer, 173 Miss. 317, 159 So. 545, 160 So. 387, 1935 Miss. LEXIS 193 (Miss. 1935).

In case of a total loss of property the insured can recover of each insurer the full amount of his policy, but in case of partial loss he can recover only his actual loss. Hartford Fire Ins. Co. v. Schlenker, 80 Miss. 667, 32 So. 155, 1902 Miss. LEXIS 303 (Miss. 1902).

6. Concurrent insurance.

Homeowners who obtained second fire insurance policy on home prior to expiration of first policy were not entitled to recover on either policy where both policies contain provision prohibiting homeowner from obtaining additional insurance. Mister v. Highlands Ins. Co., 650 F. Supp. 428, 1986 U.S. Dist. LEXIS 18010 (N.D. Miss. 1986).

In consolidated actions brought by an insured on two fire policies which contained a clause that other insurance was prohibited unless the total amount of insurance was inserted on the first page of the policy, the insurer's defense that the insured had a third policy which was not mentioned in the first two policies was without merit, where the knowledge of local agent who issued the policy would be imputed to the insurer. American Cent.

Ins. Co. v. Meredith, 228 Miss. 402, 87 So. 2d 871, 1956 Miss. LEXIS 527 (Miss. 1956).

Where several concurrent policies have been written on the same property with the consent of the respective companies, under the statute each company is liable for the full amount of its policy. Western Assurance Co. v. Phelps, 77 Miss. 625, 27 So. 745, 1900 Miss. LEXIS 31 (Miss. 1900).

7. Insurance of personal property.

The valued policy statute does not apply to personal property contained in a building, and an insured who offered no evidence as to her loss on the contents of her house, which was totally destroyed by fire, was not entitled to recover under a policy insuring the contents of the house. Home Ins. Co. v. Greene, 229 So. 2d 576, 1969 Miss. LEXIS 1252 (Miss. 1969).

Fire company can issue schedule policy covering both realty and personalty other than household and kitchen furniture and attach three-quarter clause with express stipulation limiting its application to items of personalty listed under separate heads. Darden v. Liverpool & London & Globe Ins. Co., 109 Miss. 501, 68 So. 485, 1915 Miss. LEXIS 185 (Miss. 1915).

Parties cannot agree that, for purpose of fire policy, machinery in building should be considered as personalty and subject to three-quarter clause. Darden v. Liverpool & London & Globe Ins. Co., 109 Miss. 501, 68 So. 485, 1915 Miss. LEXIS 185 (Miss. 1915).

8. Waiver of benefit of statute.

Parties cannot agree that, for purpose of fire policy, machinery in building should be considered as personalty and subject to three-quarter clause. Darden v. Liverpool & London & Globe Ins. Co., 109 Miss. 501, 68 So. 485, 1915 Miss. LEXIS 185 (Miss. 1915).

A provision in a fire insurance policy by which the insured undertook to agree to waive the statute is ineffectual. Hartford Fire Ins. Co. v. Schlenker, 80 Miss. 667, 32 So. 155, 1902 Miss. LEXIS 303 (Miss. 1902).

The statute is not waived by the insured accepting a policy, the terms of which prescribe a different rule from the one laid down in it for fixing the amount of the loss to be paid. Western Assurance Co. v. Phelps, 77 Miss. 625, 27 So. 745, 1900 Miss. LEXIS 31 (Miss. 1900).

9. Proof of value.

When an insurer enters into a contract with its eyes open and receives the premium with full knowledge of the situation, it is bound to pay the face value of the policy, notwithstanding that such amount exceeds the value of the insurable interest. Mississippi Farm Bureau Mut. Ins. Co. v. Todd, 492 So. 2d 919, 1986 Miss. LEXIS 2621 (Miss. 1986).

If insured property is totally destroyed, proof of the amount of loss is unnecessary. Birmingham Fire Ins. Co. v. McKnight, 246 Miss. 578, 151 So. 2d 409, 1963 Miss. LEXIS 483 (Miss. 1963).

In consolidated actions brought by insured on two fire policies which contained a clause that other insurance was prohibited unless the full amount of insurance was inserted on the first page of the policy, wherein insurer's defense was that insured had a third policy which was not mentioned in the first two policies, the exclusion of insurer's testimony and photographs as to value was proper. American Cent. Ins. Co. v. Meredith, 228 Miss. 402, 87 So. 2d 871, 1956 Miss. LEXIS 527 (Miss. 1956).

In an action on a fire insurance policy for the burning of a dwelling house, the admission of testimony of a general building contractor who testified as to the replacement cost of the house was not error. Paramount Fire Ins. Co. v. Anderson, 211 Miss. 372, 51 So. 2d 763, 1951 Miss. LEXIS 366 (Miss. 1951).

Where building was a total loss as result of fire, and appraisers appointed under fire policy had not valued property prior to burning at amount stated in policy, their finding was ineffective in view of valued policy law. Yorkshire Ins. Co. v. Brewer, 175 Miss. 538, 166 So. 361, 1936 Miss. LEXIS 17 (Miss. 1936).

Insured's failure to introduce proof of value did not preclude recovery on fire policy, regardless of extent of insurable interest. Hartford Fire Ins. Co. v. Clark, 154 Miss. 418, 122 So. 551, 1929 Miss. LEXIS 157 (Miss. 1929).

Defense of overinsurance in fire policy held valid. Scottish Union & Nat'l Ins. Co. v. Warren Gee Lumber Co., 118 Miss. 740, 80 So. 9, 1918 Miss. LEXIS 132 (Miss. 1918).

In view of this provision, insured's failure to furnish plans and specifications of house after demand in accordance with stipulation in policy held no defense to action to recover for loss. Mississippi Home Ins. Co. v. Barron, 91 Miss. 722, 45 So. 875, 1907 Miss. LEXIS 205 (Miss. 1907).

Policy held valid, though property overinsured. Mississippi Home Ins. Co. v. Barron, 91 Miss. 722, 45 So. 875, 1907 Miss. LEXIS 205 (Miss. 1907).

RESEARCH REFERENCES

ALR.

What constitutes "vacancy" or "unoccupancy" within fire insurance policy on building other than dwelling. 36 A.L.R.3d 505.

What are "appurtenant" private structures within provision of property insurance policy expressly extending coverage to such structures. 43 A.L.R.3d 1362.

Depreciation as factor in determining actual cash value for partial loss under insurance policy. 8 A.L.R.4th 533.

Insured's nondisclosure of information regarding value of property as ground for avoiding liability under property insurance policy. 15 A.L.R.4th 1109.

Construction and effect of provisional or monthly reporting inventory insurance. 81 A.L.R.4th 9.

What constitutes "vacant land" within meaning of liability or property insurance policy provisions. 47 A.L.R.5th 535.

Am. Jur.

43 Am. Jur. 2d, Insurance § 272.

14A Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 661 (complaint, petition, or declaration for recovery on fire policy-loss exceeding face amount).

CJS.

44 C.J.S., Insurance § 383.

§ 83-13-7. Mortgagees protected in order of priority.

When, by an agreement with the assured or by the terms of a fire insurance policy taken out by a mortgagor, the whole or any part of the loss thereon is payable to the mortgagee or mortgagees of the property for their benefit, the company shall, upon satisfactory proof of the rights and title of the parties, in accordance with such terms and agreement, pay all mortgagees protected by such policy in the order of their priority of claim, as their claims shall appear, not beyond the amount of which the company is liable. Such payments shall be, to the extent thereof, payments and satisfaction of the liabilities of the company under such policy.

HISTORY: Codes, 1892, § 2338; 1906, § 2595; Hemingway's 1917, § 5059; 1930, § 5184; 1942, § 5694.

Cross References — Notification of creditors of loss of insured merchandise by fire, see § 15-3-9.

Prohibition against disclosure of expiration date of insurance on mortgaged property, see § 83-13-10.

Requirement for fire insurance upon property securing investment of domestic insurance company, see § 83-19-51.

Exemption from execution or attachment of proceeds of insurance on property, see § 85-3-1.

Priority of conveyances of same land, see §§ 89-5-1, 89-5-5.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Priority.

1. In general.

Mississippi law presumes an equitable lien in favor of mortgagee to proceeds from insurance procured by mortgagor in his name, after agreement between parties that property will be insured for mortgagee's benefit. General Star Indem. Co. v. Pike County Nat'l Bank, 706 So. 2d 227, 1997 Miss. LEXIS 445 (Miss. 1997).

Mortgagee is entitled to payment under fire insurance policy despite absence of mortgage clause in policy in mortgagee's favor where insurance was taken out by mortgagor in order to fulfill agreement for insurance coverage; it is error for court to direct verdict against alleged mortgagee simply on basis that name does not appear on policy. Merchants Nat'l Bank v. Southeastern Fire Ins. Co., 751 F.2d 771, 1985 U.S. App. LEXIS 27780 (5th Cir. Miss. 1985).

Where the mortgagee on a second deed of trust gave both oral and written notice of the existence of the second deed of trust to the insurers on fire policies taken out by the mortgagors, and the second deed of trust provided that whatever insurance was left after payment to the first mortgagee should be payable to the second mortgagee, the insurers, in ignoring the second mortgagee's notice and settling with the mortgagors and the first mortgagee only, did so at their peril and became liable to the second mortgagee in the amount of his damage. Employers Mut. Casualty Co. v. Standard Drug Co., 234 So. 2d 330, 1970 Miss. LEXIS 1406 (Miss. 1970).

2. Priority.

Mississippi statute requiring fire insurance company, in disbursing proceeds of fire insurance policy, to pay mortgagees in order of their priority of claim, to the extent policy itself, or agreement between insured-mortgagor and mortgagee, gives mortgagee an interest in proceeds, is simply a priority statute, designed to clarify mortgagee's position of recovery in relation to others, not a statute intended to provide mortgagee with equitable lien. General Star Indem. Co. v. Pike County Nat'l Bank, 706 So. 2d 227, 1997 Miss. LEXIS 445 (Miss. 1997).

RESEARCH REFERENCES

ALR.

Right of holder of mortgage or lien to proceeds of property insurance payable to owner not bound to carry insurance for former's benefit. 9 A.L.R.2d 299.

Right of mortgagee to notice by insurer of expiration of fire insurance policy. 60 A.L.R.3d 164.

Right of mortgagee, who acquires title to mortgaged premises in satisfaction of mortgage, to recover, under fire insurance policy covering him as "mortgagee," for loss or injury to property thereafter damaged or destroyed by fire. 19 A.L.R.4th 778.

Fire insurance: insurable interest of one expecting to inherit property or take by will. 52 A.L.R.4th 1273.

Am. Jur.

43 Am. Jur. 2d, Insurance § 499.

44A Am. Jur. 2d, Insurance §§ 1614, 1791.

14A Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 662 (complaint, petition, or declaration against insurer for recovery on fire policy-mortgagees named as defendants to settle interests).

13 Am. Jur. Legal Forms 2d, Mortgages and Trust Deeds §§ 179:351 et seq. (insurance).

CJS.

44 C.J.S., Insurance § 269.

45 C.J.S., Insurance § 1326, 1327.

46 C.J.S., Insurance §§ 1630-1632, 1637.

§ 83-13-9. Mortgage clause.

Each fire insurance policy on buildings taken out or renewed on or after July 1, 1989, by a mortgagor or grantor in a deed of trust shall have attached or shall contain substantially the following mortgagee clause, viz:

Loss or damage, if any, under this policy, shall be payable to (here insert the name of the party), as ________ mortgagee (or trustee), as ________ interest may appear, and this insurance, as to the interest of the mortgagee (or trustee) only therein, shall not be invalidated by any act or neglect of the mortgagor or owner of the within described property, nor by any foreclosure or other proceedings or notice of sale relating to the property, nor by any change in the title or ownership of the property, nor by the occupation of the premises for purposes more hazardous than are permitted by this policy; and in case the mortgagor or owner shall neglect to pay any premium due under this policy, the mortgagee (or trustee) shall, on demand, pay the same. The mortgagee (or trustee) shall notify this company of any change of ownership or occupancy or increase of hazard which shall come to the knowledge of said mortgagee (or trustee) and, unless permitted by this policy, it shall be noted thereon and the mortgagee (or trustee) shall, on demand, pay the premium for such increased hazard for the term of the use thereof; otherwise this policy shall be null and void. This company reserves the right to cancel this policy at any time as provided by its terms, but in such case this policy shall continue in force for the benefit only of the mortgagee (or trustee) for thirty (30) days after notice to the mortgagee (or trustee) of such cancellation and shall then cease, and this company shall have the right on like notice to cancel this agreement. In case of any other insurance upon the within described property, this company shall not be liable under this policy for a greater proportion of any loss or damage sustained than the sum hereby insured bears to the whole amount of insurance on said property issued to or held by any party or parties having an insurable interest therein, whether as owner, mortgagee, or otherwise. Whenever this company shall pay the mortgagee (or trustee) any sum for loss or damage under this policy and shall claim that, as to the mortgagor or owner, no liability therefor existed, this company shall, to the extent of such payment, be thereupon legally subrogated to all the rights of the party to whom such payment shall be made, under all security held as collateral to the mortgage debt, or may, at its option, pay to the mortgagee (or trustee) the whole principal due or to grow due on the mortgage with interest, and shall thereupon receive a full assignment and transfer of the mortgage and of all such other securities; but no subrogation shall impair the right of the mortgagee (or trustee) to recover the full amount of ________ claim. Nothing in the foregoing prescribed form shall be construed to in any manner modify the provisions of Section 83-13-5.

HISTORY: Codes, 1906, § 2596; Hemingway's 1917, § 5060; 1930, § 5185; 1942, § 5695; Laws, 1989, ch. 410, § 3, eff from and after July 1, 1989.

Cross References — Necessity of fire insurance upon property securing investment of domestic insurance company, see § 83-19-51.

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1. In general.
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5. Mortgagee's liability for premiums.
6. Subrogation of insurer to rights of mortgagee.
7. Lien on proceeds.

1. In general.

Standard mortgage clause that is inserted in a fire insurance policy pursuant to Miss. Code Ann. § 83-13-9 creates a separate contract between the insurer and the mortgagee in which the owner has no interest. Reed v. Nationwide Mut. Fire Ins. Co., 2007 U.S. Dist. LEXIS 83517 (S.D. Miss. Nov. 9, 2007).

Notice was required for termination of a binder providing builder's risk insurance on a home since the expiration date given in a builder's risk policy is only an initial forecast of when the construction will be completed and insurance is still needed until the date that construction is in fact complete and a permanent policy has been issued. Scottsdale Ins. Co. v. Deposit Guar. Nat'l Bank, 733 So. 2d 863, 1999 Miss. App. LEXIS 19 (Miss. Ct. App. 1999).

Phrase "as interest may appear" in standard union mortgage clause and statute making loss or damage payable to mortgagee or trustee on deed of trust as interests may appear refers to amount of promissory note or actual amount of debt and any interest accrued, rather than amount of debt secured by the property or mortgagee's interest in the property. National Farmers Union Property & Casualty Co. v. First Columbus Nat'l Bank, 669 So. 2d 767, 1996 Miss. LEXIS 13 (Miss. 1996).

Insurer did not convert insureds' equitable interest in their home, which suffered fire damage, when insurer took assignment of insureds' deed of trust from bank which held the mortgage; insurer paid the mortgage owed by insureds as required by statute, and took assignment on the deed of trust to which it was entitled. Dunn v. State Farm Fire & Casualty Co., 927 F.2d 869, 1991 U.S. App. LEXIS 5301 (5th Cir. Miss. 1991).

Production of a "certificate of mailing" does not constitute conclusive proof of an insured's actual receipt of a cancellation notice. A certificate of mailing establishes a presumption that the notice reached its destination. However, this presumption may be rebutted by the insured who contends that he or she did not actually receive the notice, though mere denial of receipt is insufficient to create a triable issue of fact. In other words, proof of mailing of a notice of cancellation is sufficient proof of notice absent countervailing evidence of sufficient weight to rebut the presumption that it was received. Carter v. Allstate Indem. Co., 592 So. 2d 66, 1991 Miss. LEXIS 872 (Miss. 1991).

A 2-week delay by a mortgagee in notifying the insurer of the vacant status of insured property was reasonable under the mortgage clause of a fire insurance policy where the mortgage clause did not impose a time requirement on the mortgagee for notifying the insurance company of "any change of ownership, or occupancy or increase of hazard which shall come to the knowledge of said mortgagee. . . ," despite the fact that the property was destroyed by fire before the insurer received word that it had been abandoned. Lumbermens Mut. Casualty Co. v. Thomas, 555 So. 2d 67, 1989 Miss. LEXIS 509 (Miss. 1989).

A hazard insurer of a mobile home who failed to exercise its absolute statutory duty, pursuant to § 83-13-9, to notify the lienholder that the policy would terminate unless the renewal premium were paid was liable under the policy when fire destroyed the mobile home after the policy lapsed, even though (1) the insurer sent two notices to the owner that the policy would expire unless renewed, (2) the owner failed to renew the policy, and (3) the policy was not continuous; moreover the insurer had the same obligation apart from the statute since the policy itself contained essentially the same language as the statute. Bankers & Shippers Ins. Co. v. Meridian Naval Federal Credit

Union, 431 So. 2d 1123, 1983 Miss. LEXIS 2689 (Miss. 1983).

Where the terms "mortgagee clause" and "loss payable clause" in fire policies were ambiguous, they would be construed against the insurer, so that vendors, who held a vendor's lien on all assets of a lumber yard business, would be construed as mortgagees entitled to 10 days written notice of cancellation of coverage on equipment and materials, rather than strictly loss payees entitled to such notice only on building items, and where the vendors were given no notice of cancellation, their rights under the mortgage clause or loss payable clause were not impaired by an attempt of the insured and the insurers to cancel the policies. United States Fidelity & Guaranty Co. v. Arrington, 255 So. 2d 652, 1971 Miss. LEXIS 1291 (Miss. 1971).

This statute has the laudable purpose of prohibiting or seeking to prohibit the issuance of excessive coverage on insured property, so that, in an action to recover under a policy which had a face value of $3,000 maintained on the interest of a named insured as the mortgagee of a dwelling, after the dwelling was destroyed by fire, the limitation of the recovery balance on the indebtedness due under the mortgage to $411.75, the balance due under the mortgage, did not violate the statute. Harrison v. American Motorists Ins. Co., 245 So. 2d 577, 1971 Miss. LEXIS 1368 (Miss. 1971).

Provision rendering fire policy void if at time of its issuance the property was mortgaged or if it should thereafter be mortgaged without insurer's written consent, was ineffective to render policy void where insurer's soliciting agent knew at the time he accepted the application therefor that the property was mortgaged and that the insured was procuring a new mortgage loan to pay off the existing mortgages. Home Ins. Co. v. Northington, 198 Miss. 650, 23 So. 2d 537, 1945 Miss. LEXIS 237 (Miss. 1945).

This section [Code 1942, § 5695] applies to insurance on building by mortgagor as well as that taken out by grantor in deed of trust. Scottish Union & Nat'l Ins. Co. v. Warren Gee Lumber Co., 118 Miss. 740, 80 So. 9, 1918 Miss. LEXIS 132 (Miss. 1918).

This section [Code 1942, § 5695] does not prohibit oral agreement to issue mortgage clause. Hartford Fire Ins. Co. v. J. R. Buckwalter Lumber Co., 116 Miss. 822, 77 So. 798, 1917 Miss. LEXIS 362 (Miss. 1917).

This provision does not create a new contract independent of liability to the assured, and a mortgagee is bound by an appraisement agreement in the policy. Aetna Ins. Co. v. Cowan, 111 Miss. 453, 71 So. 746, 1916 Miss. LEXIS 320 (Miss. 1916).

2. Statute as part of policy.

Notwithstanding contention of Farmer's Home Administration that § 83-13-9 is automatically written into fire insurance policy wherein insured is grantor of deed of trust, as matter of public policy, and that Administration is thus entitled to protection provided mortgagees under that statute, statute cannot be given such broad construction in absence of mortgage clause naming Administration in homeowner's policy. Nationwide Mut. Fire Ins. Co. v. Dungan, 634 F. Supp. 674, 1986 U.S. Dist. LEXIS 27177 (S.D. Miss. 1986), aff'd, 818 F.2d 1239, 1987 U.S. App. LEXIS 7530 (5th Cir. Miss. 1987).

In a suit to collect as mortgagee on policies of fire insurance, plaintiff savings and loan association was entitled to recover on the second of two policies that were issued on the home at issue, even though the policy was void as to the homeowners because of their fraudulent representations and concealments, where, under the mortgage clause of the policy, coverage for the mortgagee could not be invalidated by any act or neglect of the homeowner; as to the insurer that had issued the first policy on the home, the mortgage clause provision of its policy was in full force and effect at the time of the fire where, contrary to statutory requirements, it had failed to give notice of cancellation to the mortgagee. Tolar v. Bankers Trust Sav. & Loan Asso., 363 So. 2d 732, 1978 Miss. LEXIS 2195 (Miss. 1978).

This section [Code 1942, § 5695] automatically becomes a part of every fire insurance policy insuring property on which there is a mortgage. United States v. Sentinel Fire Ins. Co., 178 F.2d 217, 1949 U.S. App. LEXIS 3413 (5th Cir. Miss. 1949).

Federal court in Mississippi, in deciding whether this section [Code 1942, § 5695] automatically becomes a part of every fire insurance policy insuring property on which there is a mortgage, is bound by the pertinent decisions of the Supreme Court of Mississippi. United States v. Sentinel Fire Ins. Co., 178 F.2d 217, 1949 U.S. App. LEXIS 3413 (5th Cir. Miss. 1949).

Loss payable clause recognizing rights of mortgagee automatically writes this section [Code 1942, § 5695] into the policy. Scottish Union & Nat'l Ins. Co. v. Warren Gee Lumber Co., 118 Miss. 740, 80 So. 9, 1918 Miss. LEXIS 132 (Miss. 1918).

This section [Code 1942, § 5695] automatically writes itself into every insurance contract. Bacot v. Phenix Ins. Co., 96 Miss. 223, 50 So. 729, 1909 Miss. LEXIS 49 (Miss. 1909).

3. Right of mortgagee to recover on policy.

Fact that an insurer waited one year after fire damaged an insured's home before making payment to the insured's mortgagee did not give rise to a bad faith claim by the insured because the insured had no standing to sue for breach of the standard mortgage clause required by Miss. Code Ann. § 83-13-9. Reed v. Nationwide Mut. Fire Ins. Co., 2007 U.S. Dist. LEXIS 83517 (S.D. Miss. Nov. 9, 2007).

Mississippi statute providing that each fire insurance policy on buildings which is taken out by mortgagor or grantor under deed of trust shall have attached or contain a mortgage clause providing that loss or damage shall be payable to mortgagee or trustee, as his interest may appear, automatically writes into each fire insurance policy on mortgaged property in Mississippi a standard mortgage loss payable clause; statute creates duty on part of mortgagor and insurer to attach such a clause in favor of mortgagee in each fire insurance policy on building subject to mortgage. General Star Indem. Co. v. Pike County Nat'l Bank, 706 So. 2d 227, 1997 Miss. LEXIS 445 (Miss. 1997).

Standard union mortgage clause stating that mortgagee had right to receive loss payment, even if mortgagee started foreclosure, entitled mortgagee to policy limits minus amount received from foreclosure sale, where debt exceeded policy limits and amount received from sale. National Farmers Union Property & Casualty Co. v. First Columbus Nat'l Bank, 669 So. 2d 767, 1996 Miss. LEXIS 13 (Miss. 1996).

When foreclosure does not fully satisfy mortgage debt, mortgagee may look to insurer for payment under standard union mortgage clause and may recover full amount of debt to limits of policy, but has no additional recourse against mortgagor; or mortgagee may foreclose and recover balance due under insurance policy, but has no additional recourse against insurer, if foreclosure does not fully satisfy debt. National Farmers Union Property & Casualty Co. v. First Columbus Nat'l Bank, 669 So. 2d 767, 1996 Miss. LEXIS 13 (Miss. 1996).

Holder of mortgage on property destroyed by fire could properly assign its interest in any claims and/or causes of action against insurance company arising out of loss to the property owner, with property owner remaining fully liable to mortgagee for amount still owed on mortgage, and such assignment is not champertous, as property owners who obtain assignment from mortgage company are not strangers to litigation against insurance company and have asserted interest separate and distinct from interest of mortgagee; in issues of propriety of assignment and claims of champerty, analysis is not focused on relationship between assignee and assignor but rather relationships between assignor and insurance company and assignees and insurance company. Stephen R. Ward, Inc. v. United States Fidelity & Guaranty Co., 681 F. Supp. 389, 1988 U.S. Dist. LEXIS 1902 (S.D. Miss. 1988).

Unnamed mortgagees have only equitable lien under Miss Code Anno § 83-13-9, and such lien is subject to any defenses that may be asserted against mortgagor, as provision written into fire insurance policy by virtue of statute contains place for mortgagee's name to be filled in, thereby reflecting intent on part of legislature that there be some sort of agreement between insurance company and either owner or mortgagee that insurance be provided for mortgagee, and further, statute allows insurance company to cancel policy 10 days after giving notice to mortgagee, such that if statute applied to unnamed mortgagees, insurance company's right to cancel policy would be meaningless. Nationwide Mut. Fire Ins. Co. v. Dungan, 818 F.2d 1239, 1987 U.S. App. LEXIS 7530 (5th Cir. Miss. 1987).

Mortgagee is entitled to payment under fire insurance policy despite absence of mortgage clause in policy in mortgagee's favor where insurance was taken out by mortgagor in order to fulfill agreement for insurance coverage; it is error for court to direct verdict against alleged mortgagee simply on basis that name does not appear on policy. Merchants Nat'l Bank v. Southeastern Fire Ins. Co., 751 F.2d 771, 1985 U.S. App. LEXIS 27780 (5th Cir. Miss. 1985).

Repair of premises by mortgagor after fire does not prevent mortgagee from recovering fire insurance under mortgage clause. Talman Federal Sav. & Loan Asso. v. American States Ins. Co., 468 So. 2d 868, 1985 Miss. LEXIS 2057 (Miss. 1985).

The trial court erred reversibly in failing to give a mortgagee's requested peremptory instruction that no material or substantial increase of hazard had occurred within the meaning of § 83-13-9, or within the meaning of the language of a policy of fire insurance, such as would defeat the mortgagee's claim for damages in the event of a fire, notwithstanding the fact that the insured was deeply in debt on the date of the fire, that he had been convicted of forgery, and that the premises had become vacant, where the insured had also been deeply in debt on the date the policy was issued, where he had been under indictment on the date the policy was issued, where the mortgagee's failure, if any, to notify the insurance company that the premises had become vacant, could have proximately caused or contributed to any loss suffered by the company, and where any change of ownership or occupancy did in fact become known to the insurance company within 24 hours after it had occurred. Weems v. American Sec. Ins. Co., 450 So. 2d 431, 1984 Miss. LEXIS 1710 (Miss. 1984).

A mortgagee could not invoke the provision of Miss. Code § 83-13-9 that requires an insurer to give a mortgagee ten days' notice of cancellation of an insurance policy in which the mortgagee is a loss payee, where the mortgagee itself violated another insurance provision in a policy which it had obtained and caused such policy to be voided, and where the insurer on such policy had no previous notice, actual or constructive, of the existence of the other insurance on the subject property until the property was damaged by fire. Highlands Ins. Co. v. Allstate Ins. Co., 688 F.2d 398, 1982 U.S. App. LEXIS 24974 (5th Cir. Miss. 1982).

Without ten days' notice to a mortgagee, as loss payee under a renewal fire insurance policy, the nonpayment of the premium on the renewal policy could not terminate the mortgagee's coverage pursuant to Miss. Code § 83-13-9. Highlands Ins. Co. v. Allstate Ins. Co., 688 F.2d 398, 1982 U.S. App. LEXIS 24974 (5th Cir. Miss. 1982).

Defendant fire insurer was liable to a mortgagee for the amount of its mortgage after the insured dwelling burned, notwithstanding the insurer's contention that the policy had lapsed by its own terms because the renewal premium had not been paid, where the mortgagee did not receive 10 days notice of cancellation for nonpayment of premium, as required by this section. The policy's automatic cancellation provision was ineffective to the extent it conflicted with statutory requirements. National Sec. Fire & Casualty Co. v. Mid-State Homes, Inc., 370 So. 2d 1351, 1979 Miss. LEXIS 2045 (Miss. 1979).

Where the union or standard mortgage clause is included in an insurance policy, the mortgagee is entitled to the proceeds of the policy, and the mortgagee's right to recover will not be invalidated by the act or negligence of the mortgagor of the insured's property. No act or default of any person other than the mortgagee or those claiming the proceeds under the mortgagee shall affect the rights of the mortgagee to recover in case of loss. Hartford Fire Ins. Co. v. Associates Capital Corp., 313 So. 2d 404, 1975 Miss. LEXIS 1675 (Miss. 1975).

Where a contract for the sale of a lumber yard attached a vendors' lien upon all assets of the business, such lien being in effect a mortgage, and where the mortgagees were not given any written notice of cancellation of fire policies in which they were named loss payees, the mortgagor's attempt to cancel the policies before a hurricane did not relieve the insurers of liability to the mortgagees for loss or damage to the buildings. United States Fidelity & Guaranty Co. v. Arrington, 255 So. 2d 652, 1971 Miss. LEXIS 1291 (Miss. 1971).

Failure of the mortgagee under the provisions of this section [Code 1942, § 5695] to notify the insurer of occupancy voids the policy only if the occupancy in fact increases the fire hazard. Peerless Ins. Co. v. Bailey Mortg. Co., 345 F.2d 14, 1965 U.S. App. LEXIS 5599 (5th Cir. Miss. 1965).

The manifest purpose of the notice of occupancy provision in this section [Code 1942, § 5695] is to allow the insurer to protect itself against increased risk by increasing the premiums due, and where there is no increase of risk there can be no detriment to the insurance company from failure of the mortgagee to notify it of the occupancy; and there being no forfeiture of the policy the mortgagee can recover thereunder in the event of loss. Peerless Ins. Co. v. Bailey Mortg. Co., 345 F.2d 14, 1965 U.S. App. LEXIS 5599 (5th Cir. Miss. 1965).

Where a contractor borrowing money from a bank gave a trust deed on a house he was constructing, then he obtained fire insurance on the house but through mistake the name of the bank was not inserted in the mortgage clause of the policy, and the house burned down, an equitable lien existed in the favor of the bank and it was entitled to the proceeds of the policy. Lititz Mut. Ins. Co. v. Miller, 210 Miss. 548, 50 So. 2d 221, 1951 Miss. LEXIS 293 (Miss. 1951).

In action in federal court sitting in Mississippi brought by several fire insurance companies under the Federal Interpleader Act to determine to whom the proceeds of fire insurance policies, taken out by mortgagor, should be paid, mortgagee was held entitled to the proceeds as against the assignees of the mortgagor, since this section [Code 1942, § 5695] automatically becomes a part of the policy, notwithstanding the clause was added to the policy by the insurer at mortgagee's request before the fire without the consent of the mortgagor. United States v. Sentinel Fire Ins. Co., 178 F.2d 217, 1949 U.S. App. LEXIS 3413 (5th Cir. Miss. 1949).

Pledging by mortgagee of secured notes does not bar recovery by him on policy with mortgage clause. Mechanics' & Traders' Ins. Co. v. Boyce, 114 Miss. 165, 74 So. 821, 1917 Miss. LEXIS 16 (Miss. 1917).

Mortgagee may sue on policy though his interest is less than the amount due on its face, where amount due him is the only valid liability under the policy. Bacot v. Phenix Ins. Co., 96 Miss. 223, 50 So. 729, 1909 Miss. LEXIS 49 (Miss. 1909).

4. Effects of acts of owner.

Under this section, wrongdoing by insured does not relieve insurer of obligation to pay mortgagee. Saucier v. United States Fidelity & Guaranty Co., 765 F. Supp. 334, 1991 U.S. Dist. LEXIS 8252 (S.D. Miss. 1991).

Clause in fire policy making loss payable to mortgagee as his interest might appear, and providing that mortgagee's interest should not be invalidated by any act of mortgagor, effects two policies of insurance, one to the mortgagor and the other to the mortgagee. Hennessey v. Helgason, 168 Miss. 834, 151 So. 724, 1934 Miss. LEXIS 345 (Miss. 1934).

Where loss payable clause was made payable to trustee of vendor's lien as his interest might appear, such trustee was not affected by forfeitures and breaches of warranty committed by vendee. Scottish Union & Nat'l Ins. Co. v. Warren Gee Lumber Co., 118 Miss. 740, 80 So. 9, 1918 Miss. LEXIS 132 (Miss. 1918).

5. Mortgagee's liability for premiums.

Under statute providing that, if mortgagor insures mortgaged property and fails to pay premiums, mortgagee shall pay premiums on demand, whether demand was made in reasonable time after mortgagor failed to pay is question of fact. Hennessey v. Helgason, 168 Miss. 834, 151 So. 724, 1934 Miss. LEXIS 345 (Miss. 1934).

Under statute providing that, if mortgagor insures mortgaged property and fails to pay premiums, mortgagee shall pay premiums on demand, such demand must be within reasonable time after mortgagor's failure to pay. Hennessey v. Helgason, 168 Miss. 834, 151 So. 724, 1934 Miss. LEXIS 345 (Miss. 1934).

Statute providing that, where mortgagor fails to pay premiums on insurance covering mortgaged property, mortgagee shall pay premiums on demand, imposes on mortgagor primary duty and on mortgagee secondary duty to pay premiums. Hennessey v. Helgason, 168 Miss. 834, 151 So. 724, 1934 Miss. LEXIS 345 (Miss. 1934).

Where neither owner of property nor mortgagee secured by fire policy paid premium, but insurance agent did and loss occurred, agent held entitled to money arising from loss as credit on premium as against mortgagee. Barry & Brewer v. Wright, 168 Miss. 216, 150 So. 186, 1933 Miss. LEXIS 164 (Miss. 1933).

6. Subrogation of insurer to rights of mortgagee.

Where insurer pays off loan secured by a first mortgage deed, it steps into the shoes of that creditor, and assumes that creditor's position of priority as to any remaining lien creditors; Insurer's pay-off secures full assignment of payee's rights. S. Miss. Planning & Dev. Dist. v. ALFA Gen. Ins. Corp., 790 So. 2d 818, 2001 Miss. LEXIS 178 (Miss. 2001).

Insurer's payment to insured's mortgagee was condition precedent to subrogation rights; policy stated that mortgage holder's rights would be transferred to insurer to extent of payment, and statute states that insurer is subrogated to rights of mortgagee receiving payment. National Farmers Union Property & Casualty Co. v. First Columbus Nat'l Bank, 669 So. 2d 767, 1996 Miss. LEXIS 13 (Miss. 1996).

Payment is condition precedent to insurer's subrogation rights against insured's mortgagee or trustee on deed of trust. National Farmers Union Property & Casualty Co. v. First Columbus Nat'l Bank, 669 So. 2d 767, 1996 Miss. LEXIS 13 (Miss. 1996).

Pursuant to § 83-13-9, where the insurer is not liable to the insured mortgagor but nevertheless pays a mortgagee, the insurer is subrogated to all rights of the mortgagee. McGory v. Allstate Ins. Co., 527 So. 2d 632, 1988 Miss. LEXIS 249 (Miss. 1988).

An insurer becomes subrogated to the rights of its insured's mortgagee when, but not before, the insurer makes payment to the mortgagee. Great American Ins. Co. v. Smith, 252 Miss. 62, 172 So. 2d 558, 1965 Miss. LEXIS 1162 (Miss. 1965).

An insurer not liable to the mortgagor will, upon paying mortgagee the amount of his indebtedness, be subrogated to the mortgagee's rights, and is entitled to a transfer of the deed of trust, notes, and all security thereunder. Great American Ins. Co. v. Smith, 252 Miss. 62, 172 So. 2d 558, 1965 Miss. LEXIS 1162 (Miss. 1965).

Attempted subrogation agreement between fire insurer and mortgagee, whereby insurer, which denied liability to insured upon fire loss because of mortgages on the property, admitted liability to mortgagee only on condition that upon payment the mortgagee would issue to the insurer a subrogation receipt, was invalid, and payment by insurer to mortgagee had the effect of fully liquidating the mortgage debt so that insured was entitled to cancelation of the mortgage and of the subrogation receipt. Home Ins. Co. v. Northington, 198 Miss. 650, 23 So. 2d 537, 1945 Miss. LEXIS 237 (Miss. 1945).

This statute does not have the effect of subrogating an insurer, paying a loss to a mortgagee, to the rights of the mortgagee against an accommodation endorser of the note secured, where the accommodation endorser became such under an agreement with the maker that he would procure insurance on the mortgaged property with the loss payable to the mortgagee as his interest might appear. Wright v. North River Ins. Co., 23 F.2d 548, 1928 U.S. App. LEXIS 3202 (5th Cir. Miss.), cert. denied, 277 U.S. 604, 48 S. Ct. 601, 72 L. Ed. 1011, 1928 U.S. LEXIS 834 (U.S. 1928).

Insurer, paying mortgagee and not alleging or proving that it was not liable to mortgagor, could not be subrogated to mortgagee's rights under subrogation provision. Hartford Fire Ins. Co. v. Green, 148

Miss. 627, 114 So. 865, 1927 Miss. LEXIS 92 (Miss. 1927).

7. Lien on proceeds.

Deed of trust lender was entitled to equitable lien in proceeds of fire insurance policy, which was purchased by deed of trust borrowers' grantee in grantee's own name following quit claim deed that obligated grantee to perform all of borrowers' obligations under deed of trust agreement, where agreement obligated borrowers to procure insurance protecting property. General Star Indem. Co. v. Pike County Nat'l Bank, 706 So. 2d 227, 1997 Miss. LEXIS 445 (Miss. 1997).

Deed of trust lender, in its capacity as party with equitable lien in proceeds of insurance policy purchased by record owner of deed of trust property, was subject to any substantive defenses asserted by insurer against record owner. General Star Indem. Co. v. Pike County Nat'l Bank, 706 So. 2d 227, 1997 Miss. LEXIS 445 (Miss. 1997).

Proof of loss which was timely filed by deed of trust lender under policy purchased by party with record title to deed of trust property was sufficient to protect lender's interest in insurance proceeds, which could not be defeated by titleholder's failure to file proof of loss. General Star Indem. Co. v. Pike County Nat'l Bank, 706 So. 2d 227, 1997 Miss. LEXIS 445 (Miss. 1997).

RESEARCH REFERENCES

ALR.

What constitutes "legal representative" or "personal representative" entitled to receive insurance proceeds on account of loss suffered by deceased. 40 A.L.R.4th 255.

Duty of mortgagee of real property with respect to obtaining or maintenance of fire or other casualty insurance protecting mortgagor. 42 A.L.R.4th 188.

Am. Jur.

14A Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 667 (complaint, petition, or declaration for recovery on fire policy-by mortgagee of insured property).

13 Am. Jur. Legal Forms 2d, Mortgages and Trust Deeds §§ 179:351 et seq. (insurance).

CJS.

44 C.J.S., Insurance § 499.

§ 83-13-10. Restrictions on disclosure of expiration date of insurance on mortgaged property.

(1) When a real property deed of trust or mortgage or a lending agreement in connection with a loan on real property provides that a mortgagor or borrower shall furnish insurance upon the mortgaged property, the mortgagee, assignee or creditor shall not disclose expiration dates or other policy information to other persons or parties, directly or indirectly, and such other persons or parties shall not request the disclosure of such information, so as to enable any person or party to solicit said insurance or any renewal thereof, without first obtaining the written consent of the policyholder for such disclosure to be made when the mortgagee, assignee or creditor has been advised in writing by the insurer or its agent that the insurance on the property will be cancelled or will not be renewed.

(2) Willful violation of this section by any mortgagee, assignee or creditor, or by other persons or parties who may request the disclosure of such information from such mortgagee, assignee or creditor, shall be punishable by a fine not to exceed Five Hundred Dollars ($500.00) for each violation.

HISTORY: Laws, 1974, ch. 516, §§ 1, 2, eff from and after passage (approved April 4, 1974).

Cross References — Limitation on amount of fire insurance on property, see § 83-13-5.

Priority of mortgagees protected by fire insurance, see § 83-13-7.

§ 83-13-11. Conditions to be stated in full.

In all insurance against loss by fire the condition of insurance shall be stated in full, and the rules and bylaws of the company shall not be considered as a warranty or a part of the contract except so far as they are incorporated in full into the policy and are not in conflict with this chapter.

HISTORY: Codes, 1906, § 2597; Hemingway's 1917, § 5061; 1930, § 5186; 1942, § 5696.

Cross References — Conditions of life insurance contracts, see § 83-7-1.

Necessity of fire insurance on property securing investment of domestic insurance company, see § 83-19-51.

JUDICIAL DECISIONS

1. In general.

Waiver of provision of policy by insurer after issuance held not within this section [Code 1942, § 5696]. Caledonian Fire Ins. Co. v. Shepherd, 111 Miss. 175, 71 So. 314, 1916 Miss. LEXIS 263 (Miss. 1916).

RESEARCH REFERENCES

ALR.

Remedies of insured other than direct action on policy where fire on other property insurer refuses to comply with policy provisions for appointment of appraisers to determine amount of loss. 44 A.L.R.2d 850.

Insured's discontinued breach of warranty relating to use or keeping of prohibited articles as barring recovery on fire policy. 44 A.L.R.2d 1048.

Insurer's waiver of, or estoppel to assert, lack of insurable interest in property insured under fire policy. 91 A.L.R.3d 513.

Fire insurance: insurable interest of one expecting to inherit property or take by will. 52 A.L.R.4th 1273.

Insurer's duty, and effect of its failure, to provide insured or payee with copy of policy or other adequate documentation of its terms. 78 A.L.R.4th 9.

Am. Jur.

43 Am. Jur. 2d, Insurance § 70.

CJS.

44 C.J.S., Insurance §§ 388-390.

§ 83-13-13. Proof of loss.

In case of destruction or damage of property by fire where the same is insured against fire, it shall be the duty of the insurance company or companies liable for such loss, within a reasonable time after receiving notice thereof, to furnish to the insured proper blanks upon which to make the required proof of such loss, with full directions as to what proof is required to secure the payment of the policy. If the insurance company fails to comply with this section, the failure of the insured to make proper proof of loss prior to the suit shall be no defense to a suit upon the policy, and in all cases the insured shall have a reasonable time in which to make such proof after the blanks and directions are received.

HISTORY: Codes, 1906, § 2593; Hemingway's 1917, § 5057; 1930, § 5187; 1942, § 5697.

Cross References — Notification of creditor of loss of insured merchandise by fire, see § 15-3-9.

JUDICIAL DECISIONS

1. In general.

Arguable reason to deny fire damage claim exists where insurance company, at time it denies claim, knows of substantial facts supporting arson defense; insurer can prevail on arson defense if it can show incendiary origin of fire, motive on part of insured to burn property, and opportunity of insured or his agent to burn property; insurance company is entitled to rely on conclusions of independent investigator engaged by company who discovered evidence suggesting that fire was of incendiary origin; presence of bars on windows and fact that doors to insured premises were locked tends to negate possibility that someone other than insured or his tenant entered house and set fire; evidence of incendiary origin and opportunity, combined with evidence tending to show that insured was experiencing financial difficulty at time of fire, although not particularly compelling, established motive of insured to burn property, and gave insurance company arguable reason to deny claim sufficient to avoid inference that company acted in bad faith. Sutton v. Northern Ins. Co., 681 F. Supp. 1221, 1988 U.S. Dist. LEXIS 2856 (S.D. Miss. 1988).

If insurance company, by its habit of business, creates in mind of policy holder belief that payment may be delayed until demanded, or otherwise waives right to demand forfeiture, this is binding on company notwithstanding there may not have been compliance with express letter of policy, but that principle has no application unless custom or usage was one of which insured had knowledge and upon which he relied, and this must apply equally to all types of insurance relationships. Stephen R. Ward, Inc. v. United States Fidelity & Guaranty Co., 681 F. Supp. 389, 1988 U.S. Dist. LEXIS 1902 (S.D. Miss. 1988).

In an action by a wholesale sporting goods dealer to recover insurance policy proceeds for a fire loss, the policy requirement that the insured furnish an inventory of the property damaged and destroyed within 60 days after loss was waived where, inter alia, the insurer failed to furnish the insured with the proper forms, as required by this section. United States Fidelity & Guaranty Co. v. Whitfield, 355 So. 2d 307, 1978 Miss. LEXIS 1961 (Miss. 1978).

Under this section [Code 1942, § 5697], insurers could not raise the defense of no proof of loss when proper forms had not been furnished, and fire policy loss payees, after securing proof of loss forms elsewhere when their request to the insurers went unheeded, were not barred from testifying to value in excess of that stated in their proof of loss forms. United States Fidelity & Guaranty Co. v. Arrington, 255 So. 2d 652, 1971 Miss. LEXIS 1291 (Miss. 1971).

RESEARCH REFERENCES

ALR.

Denial of liability as waiver of proofs of loss required by insurance policy. 49 A.L.R.2d 161.

Necessity and sufficiency of insurer's demand, under fire insurance policy, for examination of insured or his books or papers, or for proofs of loss, certificates, or sworn statements. 4 A.L.R.3d 631.

Overvaluation in proof of loss of property insured as fraud avoiding fire insurance policy. 16 A.L.R.3d 774.

Am. Jur.

44 Am. Jur. 2d, Insurance §§ 1444 et seq.

14A Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 323 (answer containing defense as to proof of loss not timely filed-policy provision set forth); Form No. 333 (answer containing defense as to failure to give notice or make sufficient proof of loss); Form No. 334 (instructions to jury as to proof of loss); Form No. 343 (complaint, petition, or declaration-allegation as to waiver of proof of loss-investigation by insurer after notice of loss); Form No. 346 (instruction to jury as to waiver of proof of loss-acceptance of proof in different format-effect of insurer's failure to furnish blank form).

17 Am. Jur. Proof of Facts 2d 103, "Vacancy" of Insured Commercial Structure.

CJS.

45 C.J.S., Insurance §§ 1445-1492.

§ 83-13-15. Repealed.

Repealed by Laws, 1977, ch. 341, eff from and after passage (approved March 11, 1977).

§ 83-13-15. [Codes, 1906, § 2594; Hemingway's 1917, § 5058; 1930, § 5188; 1942, § 5698; Laws, 1934, ch. 299]

Editor's Notes — Former § 83-13-15 required an insurance company to notify the commissioner of insurance of the adjustment or settlement of any loss by fire to property located in Mississippi.

§ 83-13-17. Industrial fire insurance policies.

(1) Industrial fire insurance policies are defined as policies issued by companies which write fire insurance through weekly premium agents operating on the debit agency system and which meet the other requirements of this section. Any such policy with limits in excess of Fifteen Hundred Dollars ($1500.00) may be written by such weekly premium agents operating on a debit system or by any agent qualified and licensed to write fire insurance in the State of Mississippi, and in the case of policies over Fifteen Hundred Dollars ($1500.00) written by agents other than weekly premium agents operating on a debit system, premiums may be collected as much as six (6) months in advance on the basis of filings made and approved by the Commissioner of Insurance as otherwise provided in this title. On all other industrial fire policies in the State of Mississippi, carriers and agents shall not collect premiums for more than four (4) months in advance.

The limit of risk of all industrial fire insurance policies issued as such in the State of Mississippi shall not exceed Forty Thousand Dollars ($40,000.00) on any one (1) dwelling risk of fire and allied lines, nor Twenty Thousand Dollars ($20,000.00) on the contents risk of fire and allied lines on any one (1) dwelling, nor Twenty Thousand Dollars ($20,000.00) on the risk of real or personal property loss resulting from burglary or theft.

(2) The Commissioner of Insurance shall generally supervise and regulate the operation of industrial fire insurance and allied lines.

HISTORY: Codes, 1942, § 5698.5; Laws, 1958, ch. 453, §§ 1-3; Laws, 1966, ch. 530, § 1; Laws, 1975, ch. 407; Laws, 1980, ch. 406; Laws, 1983, ch. 346; Laws, 1987, ch. 324, § 1; Laws, 1987, ch. 422, § 51; Laws, 1993, ch. 310, § 1; Laws, 2004, ch. 523, § 2, eff from and after July 1, 2004.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-13-19. Unauthorized companies denied access to courts.

No action shall be maintained by any insurance company in any court in the state upon any policy or contract of fire insurance issued upon any property situated in the state by any company, association, partnership, individual, or individuals that have not been authorized to transact such insurance business in this state.

HISTORY: Codes, 1892, § 2347; 1906, § 2652; Hemingway's 1917, § 5118; 1930, § 5199; 1942, § 5709.

Cross References — Regulation of placement of direct lines of insurance with unlicensed insurers, see §§ 83-21-17 et seq.

RESEARCH REFERENCES

Am. Jur.
44 Am. Jur. 2d, Insurance §§ 763-771.

§ 83-13-21. Information required of insurers in case of fire losses.

(1) The State Chief Deputy Fire Marshal, the Commissioner of Insurance or any other authorized law enforcement authority charged with the responsibility of investigating a fire loss of real or personal property which may have resulted from a fire of incendiary origin may require, in writing, any insurance company insuring the loss under investigation to release any information in its possession which is pertinent to such a loss. The information shall include, but is not limited to:

(a) Any insurance policy relevant to a fire loss under investigation and any application for such a policy;

(b) Policy premium payment records;

(c) History of previous claims made by the insured for fire loss; and

(d) Material relating to the investigation of the loss, including statements of any person, proof of loss, and any other relevant information or evidence.

(2) In the absence of malice any insurance company or agent thereof who furnishes information on its behalf shall be immune from liability for damages in a civil action arising by virtue of compliance with the provisions of this section.

(3) As used in this chapter, "insurance company" shall include the Mississippi Insurance Underwriting Association.

(4) Any insurance company providing information to an authorized agency pursuant to subsection (1) of this section, or any owner, insured tenant or resident of property which is the subject of a report, shall have the right to request of such agency relevant information in accordance with Section 45-11-1.

(5) Any insurance company that willfully violates the provisions of this section shall be guilty of a misdemeanor and, upon conviction, shall be fined not more than One Thousand Dollars ($1,000.00) and the Commissioner of Insurance may revoke the license of such company to transact the business of insurance in this state.

HISTORY: Laws, 1981, ch. 473, § 1; Laws, 1983, ch. 384; Laws, 1988, ch. 584, § 7; Laws, 1998, ch. 406, § 1, eff from and after July 1, 1998.

Cross References — Duty of state fire marshal to investigate causes of fires, see § 45-11-1.

Authorization for the board of supervisors of any county and the governing body of any municipality to contribute funds directly to any fire protection district or volunteer fire department serving the county or municipality to meet any standards established by the commissioner of insurance as provided in this section, see § 83-1-39.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

RESEARCH REFERENCES

ALR.

Right of innocent insured to recover under fire policy covering property, intentionally burned by another insured. 11 A.L.R.4th 1228.

§ 83-13-23. Insurer required to pay volunteer fire department for protecting property insured by insurer.

Any insurance company shall pay to the responsible volunteer fire department a minimum of One Hundred Dollars ($100.00) for each initial response to save from destruction by fire any structures which are located in areas rated as Class 9 or 10 and which are insured by that insurance company.

HISTORY: Laws, 1991, ch. 540, § 1; Laws, 1994, ch. 482, § 1, eff from and after passage (approved March 22, 1994).

OPINIONS OF THE ATTORNEY GENERAL

There is no authority for a municipality to charge a fee of $ 500.00 to an insurance company providing fire insurance coverage to its insured in the event of a fire within the municipality to reimburse the municipality for the costs of fighting the fire. Tyner, Apr. 6, 2001, A.G. Op. #01-0198.

§ 83-13-25. Form to be used by fire departments for minimum payments from insurers.

The Commissioner of Insurance shall prepare a uniform form to be used by fire departments for the minimum payments. All insurance companies doing business in the state shall accept the form authorized by the commissioner.

HISTORY: Laws, 1991, ch. 540, § 2, eff from and after July 1, 1991.

CHAPTER 14.

HOMEOWNERS' AND FARMOWNERS' INSURANCE [REPEALED]

Sec.
83-14-1 through 83-14-7. Repealed.

§§ 83-14-1 through 83-14-7. Repealed.

Repealed by Laws, 1987, Ch 422, § 33, eff from and after January 1, 1988. § 83-14-1 through § 83-14-7. [En Laws, 1975, ch 469, §§ 1-4]

Editor's Notes — Former § 83-14-1 provided that multiple line insurance companies could combine in a single policy the perils of fire and allied lines with the perils of casualty insurance.

Former § 83-14-3 provided that combined fire and casualty insurance be issued only on approved standard policy forms, and restricted coverage to homeowners and farmowners.

Former § 83-14-5 provided for audits of the rates charged for combined fire and casualty insurance.

Former § 83-14-7 provided that companies issuing combined insurance also offer comprehensive dwelling policies.

CHAPTER 15.

TITLE INSURANCE

Sec.

83-15-1.	Formation of company.
83-15-3.	License; continuous agent certificate.
83-15-5.	Capital requirements.
83-15-7.	Reserve for losses.
83-15-9.	Reserve for unearned premiums and reinsurance.
83-15-11.	State and political subdivisions may secure title insurance.

§ 83-15-1. Formation of company.

Companies may be formed in the same manner provided in this chapter for the purposes of abstracting title to real estate, furnishing information in relation thereto, and insuring owners and others interested therein against loss by reason of incumbrances and defective titles. Such companies shall not be subject to the provisions of this chapter except as regards the manner of their formation as follows, to wit: Any company, before it shall issue any policy of insurance or guaranty, shall file with the insurance commissioner a certified copy of the record of the certificate of its organization in the office of the secretary of state, and shall obtain from the commissioner of insurance his certificate that it has complied with the laws applicable to it and is authorized to do such business. Every corporation which issues policies of title insurance or guaranty shall, on or before the first day of March of each year, file in the office of the insurance commissioner a statement such as he may require, of its condition and of its affairs for the year ending on the preceding thirty-first of December, signed and sworn to by its president, secretary, treasurer, or one of its directors; and for neglect to file such annual statement shall be liable to the same penalties as are imposed upon insurance companies generally.

HISTORY: Codes, 1892, § 2336; 1906, §§ 2588-2590; Hemingway's 1917, §§ 5052-5054; 1930, § 5164; 1942, § 5671; Laws, 1952, ch. 297; Laws, 1958, ch. 441 (approved February 7, 1958).

Cross References — Exemption of title insurance company from penalty for practice of law without license, see § 73-3-55.

Procedure for organizing insurance company, see § 83-19-11.

RESEARCH REFERENCES

ALR.

Measure, extent, or amount of recovery on policy of title insurance. 60 A.L.R.2d 972.

Duty of applicant or his agent to disclose facts arising or discovered after application for title insurance. 75 A.L.R.3d 600.

Title insurance: exclusion of liability for defects, liens, or encumbrances created, suffered, assumed, or agreed to by the insured. 87 A.L.R.3d 515.

What constitutes a charge, encumbrance, or lien within contemplation of title insurance policy. 87 A.L.R.3d 764.

Construction of clause in title insurance policy excepting defects resulting from the rights of parties in possession. 94 A.L.R.3d 1188.

Defect in, or condition of, adjacent land or way as within coverage of title insurance policy. 8 A.L.R.4th 1246.

Title insurance company's rights in title information. 38 A.L.R.4th 968.

Am. Jur.

44 Am. Jur. 2d, Insurance §§ 1440-1442.

CJS.

45 C.J.S., Insurance §§ 1269-1284.

Practice References.

Business Insurance Law and Practice Guide, (Matthew Bender).

Insuring Real Property (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-15-3. License; continuous agent certificate.

The commissioner shall annually license such companies as issue policies of title insurance or contracts of guaranty and issue continuous agent certificates as prescribed in Sections 83-5-73 and 83-17-5, Mississippi Code of 1972, and shall have the same power and authority to visit and examine such companies as he has in the case of domestic insurance companies. But persons licensed as fire insurance agents and persons who are practicing attorneys at law may act as agent for any such company without additional license.

HISTORY: Codes, 1892, § 2336; 1906, §§ 2588-2590; Hemingway's 1917, §§ 5052-5054; 1930, § 5164; 1942, § 5671; Laws, 1952, ch. 297; Laws, 1958, ch. 441; Laws, 1990, ch. 355, § 1, eff from and after July 1, 1990.

Cross References — Regulation of agents, see § 83-17-1 et seq.

RESEARCH REFERENCES

Am. Jur.

44 Am. Jur. 2d, Insurance §§ 1440-1442.

CJS.

45 C.J.S., Insurance §§ 1269 et seq.

§ 83-15-5. Capital requirements.

(1) A corporation created as herein provided shall not issue any title insurance policy until it has capital of not less than One Hundred Fifty Thousand Dollars ($150,000.00) and surplus of not less than Seventy-five Thousand Dollars ($75,000.00). The total amount of any policy issued by such corporation without reinsurance shall not exceed fifty percent (50%) of the capital and surplus of the company, as reflected by its latest statement to the commissioner. In transactions where a primary risk is carried by another title insurance company, a domestic title insurance company may issue its reinsurance or coinsurance for an amount not exceeding its capital and surplus.

(2) A corporation created as herein provided shall deposit with the State Treasurer fifty percent (50%) of its capital stock, either in cash or in such bonds or securities in which the company is authorized by law to invest its funds. Upon such deposit and evidence, by affidavit or otherwise, satisfactory to the Commissioner of Insurance that the capital and surplus is all paid in and that

the company is the actual and unqualified owner of the securities representing the paid-up capital and surplus, he shall issue to the company his certificate authorizing it to transact business in this state.

HISTORY: Codes, 1892, § 2336; 1906, §§ 2588-2590; Hemingway's 1917, §§ 5052-5054; 1930, § 5164; 1942, § 5671; Laws, 1952, ch. 297; Laws, 1958, ch. 441; Laws, 2001, ch. 433, § 2, eff from and after July 1, 2001.

Cross References — Capital required for other classes of companies, see § 83-19-31.

RESEARCH REFERENCES

ALR.
Measure, extent, or amount of recovery on policy of title insurance. 60 A.L.R.2d 972.

Am. Jur.
44 Am. Jur. 2d, Insurance §§ 1440-1442.

CJS.
45 C.J.S., Insurance §§ 1269 et seq.

§ 83-15-7. Reserve for losses.

A corporation created as provided in this chapter shall establish and maintain a reserve for losses in an amount which shall be not less than (1) ten percent (10%) of the amount of all premiums received by the corporation on and after January 1, 1952, or (2) Fifty Thousand Dollars ($50,000.00) whichever is the lesser.

HISTORY: Codes, 1892, § 2336; 1906, §§ 2588-2590; Hemingway's 1917, §§ 5052-5054; 1930, § 5164; 1942, § 5671; Laws, 1952, ch. 297; Laws, 1958, ch. 441 (approved February 7, 1958).

Cross References — Reserves required of insurance companies, see § 83-5-23.
Reserve required of mutual company, see § 83-31-31.

RESEARCH REFERENCES

ALR.
Measure, extent, or amount of recovery on policy of title insurance. 60 A.L.R.2d 972.

Am. Jur.
44 Am. Jur. 2d, Insurance §§ 1440-1442.

CJS.
45 C.J.S., Insurance §§ 1269 et seq.

§ 83-15-9. Reserve for unearned premiums and reinsurance.

A corporation created as provided in this chapter shall establish, segregate and maintain, in addition to the reserve for losses as provided in Section 83-15-7, a reserve for unearned premiums and reinsurance during the period hereinafter provided, which shall at all times and for all purposes be deemed and shall constitute unearned portions of the original premiums and shall be charged as a reserve liability of such corporation in determining its financial condition. The assets constituting the unearned premium reserve shall be withdrawn from the use by the corporation for its general purposes, shall be impressed with a trust for the benefit of the corporation's title insurance policyholders, and shall be available for reinsurance of title insurance policies in the event of the insolvency of the corporation. The income from such unearned premium reserve shall be included in the general income of the corporation and may be used by such corporation for any lawful corporate purposes. The unearned premium reserve of every corporation shall be cumulative and shall consist of:

(a) An amount equal to the unearned premium reserve previously required to be held pursuant to Section 83-15-9 as of March 4, 1977;

(b) The amount of all additions required to be made to such reserve by this section; and less

(c) The withdrawals from such reserve as required by this section.

On the last day of each month after March 4, 1977, each corporation shall add to its unearned premium reserve, with respect to each title insurance policy or contract or reinsurance agreement issued by it, a sum equal to ten percent (10%) of all premiums received during such month. The amounts set aside as additions to such unearned premium reserve shall be deducted in determining the net income of the corporation. Upon the expiration of one hundred eighty (180) months after the month of the issuance of each title insurance policy, contract or reinsurance agreement that portion of the assets of the unearned premium reserve attributable to said title insurance policy, contract or reinsurance agreement shall be released and withdrawn from said reserve, shall no longer constitute part of said reserve, shall be included in the income of the corporation, and may then be used by the corporation for any lawful corporate purposes.

HISTORY: Codes, 1892, § 2336; 1906, §§ 2588-2590; Hemingway's 1917, §§ 5052-5054; 1930, § 5164; 1942, § 5671; Laws, 1952, ch. 297; Laws, 1958, ch. 441; Laws, 1977, ch. 328, § 2, eff from and after passage (approved March 4, 1977).

Editor's Notes — Section 1 of ch. 328, Laws of 1977, provides:

"SECTION 1. The purposes of this act [amending Code 1972 § 83-15-9] are to require the segregation of assets constituting unearned premium reserves from the general assets of title insurance companies, and to codify current interpretations of Section 83-15-9 by the Department of Insurance and the Attorney General. Section 83-15-9 prevents a title insurance company from using the assets constituting the unearned premium reserve for general corporate purposes or for purposes other than the protection of title insurance policyholders, and under this amendment the same restrictions will continue to apply."

Cross References — Reserve liabilities of life insurance companies, see §§ 83-7-21 et seq.

Determination of reserve liabilities of companies other than life and real estate title insurance, see § 83-13-3.

RESEARCH REFERENCES

ALR.
Measure, extent, or amount of recovery on policy of title insurance. 60 A.L.R.2d 972.

Am. Jur.
44 Am. Jur. 2d, Insurance §§ 1440-1442.

CJS.
45 C.J.S., Insurance §§ 1269 et seq.

§ 83-15-11. State and political subdivisions may secure title insurance.

The State of Mississippi, its agencies, special districts, counties, municipalities, commissions, and other public bodies authorized by law to acquire real estate, or an interest in real estate, hereafter acquiring real estate or an interest in real estate are hereby authorized, in their discretion, to secure the protection of title insurance from companies qualified to do business in this state.

The action of any such public body which heretofore has secured the protection of such title insurance is hereby ratified, approved, and confirmed.

The authority hereby conferred to such public bodies by this section shall be limited to real estate or an interest in real estate hereafter acquired by such public bodies in the furtherance of any BAWI, port, housing, industrial program, or other development authorized by law.

HISTORY: Codes, 1942, § 5671.5; Laws, 1960, ch. 372, §§ 1-3.

RESEARCH REFERENCES

Am. Jur.
44 Am. Jur. 2d, Insurance §§ 1440-1442.

CJS.
45 C.J.S., Insurance §§ 1269 et seq.

CHAPTER 17.

INSURANCE AGENTS, SOLICITORS, OR ADJUSTERS

Article 1. General Provisions. 83-17-1
Article 2. Licensing of Insurance Producers. 83-17-51
Article 3. Regulation of Agents for Life, Health, or Accident Insurers. [Repealed]. 83-17-101
Article 5. Regulation of Agents for Fire and Other Insurers. [Repealed]. 83-17-201
Article 6. Prelicensing and Continuing Education for Insurance Agents; Required for Licensure. 83-17-251
Article 7. Remedies of Agents. [Repealed]. 83-17-301
Article 9. Licensing of Insurance Adjusters. 83-17-401
Article 11. Licensing of Public Adjusters. 83-17-501

ARTICLE 1.

GENERAL PROVISIONS.

Sec.
83-17-1. Agent defined.
83-17-3. Personal liability.
83-17-5. Agent certificate; notification of nonrenewal required.
83-17-7. Commission to unauthorized agent unlawful; employees or authorized agents of limited license rental car company may receive commission under rental car company's limited license.
83-17-9 and 83-17-11. Repealed.
83-17-13. Penalty for signing blank policy.
83-17-15 and 83-17-17. Repealed.
83-17-19. Penalty for soliciting without license.
83-17-21. Policies to be written through licensed agents.
83-17-23. Repealed.
83-17-25. Duration of privilege licenses.
83-17-27 through 83-17-35. Repealed.
83-17-37. Expiration of license; application for renewal.
83-17-39. Examination of applicants; classification of applicants; textbooks and learning materials.
83-17-41. Licensing by type or kind of insurance; sanctions for selling type or kind of insurance for which not properly licensed.
83-17-43. Repealed.
83-17-45. Prohibited acts; liability.
83-17-47. Commissioner's subpoena power.

§ 83-17-1. Agent defined.

Whenever used in this chapter, the following words shall have the meanings ascribed herein unless the context clearly indicates otherwise:

(a) "Agent" means an insurance producer as defined in this section.

(b) "Nonactive agent" means an individual who is retired, disabled or has not obtained from the Commissioner of Insurance a current continuous certificate. A nonactive agent shall not solicit new business or service existing businesses, but may receive renewal commissions.

(c) "Supervising general agent" refers to and includes any person, partnership, association or corporation having authority to serve as trustees, managers or administrators, except attorneys at law, for such licensed insurance companies or their insureds in the handling of insurance programs underwritten by such licensed insurance companies, or in which they may be participating.

(d) "Excess risk" means all or any portion of an insurance risk or contract of annuity for which application is made to an agent and which exceeds the amount of insurance or annuity which will be provided by the insurer for which such agent is licensed.

(e) "Rejected risk" means an insurance risk or annuity contract for which application has been made to an agent and which insurance or annuity contract is declined by the insurer for which such agent is licensed.

(f) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

(g) "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

(h) "Controlled business" means policies of insurance to be issued to a producer, agent or to his relatives, business associates, employers or employees, or in which they or either of them have an interest. No license shall be granted or renewed to any agent or producer until the applicant certifies with the Commissioner of Insurance that the applicant shall in good faith engage in the insurance business as agent or producer, and that he is not seeking a license for the purpose of acquiring or saving commissions, premiums or other valuable considerations on "controlled business." A violation of this paragraph shall be deemed to be probable if the commissioner finds that during any twenty-four-month period aggregate commissions or other compensations accruing in favor of the applicant with respect to his own interests or those of his family, relatives, employers, employees or business associates, as provided herein, have exceeded or will exceed thirty-five percent (35%) of the aggregate amount of commissions accruing to him as agent or his agency during such period of time. Nothing herein contained shall prohibit the licensing under a limited license as to motor vehicle physical damage insurance, any person employed by or associated with a motor vehicle sales agency with respect to insurance on a motor vehicle sold, serviced or financed by it. Whenever employment is terminated of any such person employed by or associated with any such agency, the Commissioner of Insurance shall be notified, and the license shall be cancelled immediately. It is further provided that the provisions of this paragraph likewise shall not apply with respect to sales of insurance by a lender or its affiliate covering the insurable interest of the lender.

HISTORY: Codes, 1892, § 2342; 1906, § 2615; Hemingway's 1917, § 5078; 1930, § 5196; 1942, § 5706; Laws, 1989, ch. 543, § 1; Laws, 2001, ch. 510, § 31; Laws, 2009, ch. 448, § 5; brought forward without change, Laws, 2015, ch. 364, § 5, eff from and after July 1, 2015.

Cross References — Privilege taxes on insurance agents, see §§ 27-15-85 et seq.

Penalty for acting as adjuster without license, see § 83-17-17.

Definition of agent for surety company, see § 83-27-7.

License required of agent or representative, as defined in this section, of sponsor of legal expense insurance plan, see § 83-49-47.

Penalty for acting as agent of company not complying with law, see § 97-23-31.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Who are agents.
3. Agents' powers, generally.
4. Agents' knowledge as imputable to insurer; generally.
5. —Notice to agent of claim or loss.
6. —Knowledge binding notwithstanding contrary provision in application or policy.
7. —Question of fact as to what agent knew.
8. —Agent's exercise of discretion in determining insurability.
9. Agents' act or statements as binding insurer—generally.
10. —Premiums.
11. —Waiver.

1. In general.

In an action pertaining to the cancellation of an insurance policy which turned on whether the procuring agent was in fact or law acting on behalf of the insurer when the policy was canceled, it was error for the court to instruct the jury in the exact language found in the statute. While the language of the statute seemed all encompassing, prior judicial interpretations of it had narrowed its scope. Booker v. Pettey, 770 So. 2d 39, 2000 Miss. LEXIS 196 (Miss. 2000).

Miss. Code Annotated § 83-17-1 is written in broadest terms, and it creates agency relationships where they would not exist at common law. State v. Richardson, 817 F.2d 1203, 1987 U.S. App. LEXIS 6847 (5th Cir. Miss. 1987).

Life insurance corporation did not enter into binding contract for credit life and disability insurance with mortgagee when mortgagee indicated on mortgage loan disclosure form prepared by mortgagor that he wished to obtain credit insurance, and mortgagor, as agent for insurance company, was not authorized to accept risk of any kind or to make any contract of insurance, insurance company is not liable for acts of agents outside scope of their working authority under agency relationship, and mortgagor did not have authority to waive insurance company's requirement of submission of written application completed by mortgagee, and further, Mississippi Code § 83-17-1 is not applicable where mortgagor was acting as agent for mortgagee, as agent for insurance company, and as agent of employee bank, such that mortgagee cannot pick and choose principal that must bear burden of any errors caused by their shared agent's errors. Hancock Bank v. Integon Life Ins. Corp., 660 F. Supp. 459, 1986 U.S. Dist. LEXIS 17682 (S.D. Miss. 1986).

Insurance company may not terminate employee's coverage under group insurance plan without notice to employee for failure of employer to pay premiums collected by employer from employee. Dearman v. Prudential Ins. Co., 727 F.2d 479, 1984 U.S. App. LEXIS 24394 (5th Cir. Miss. 1984).

The purpose of the statute defining an insurance agent is to prevent insurance companies from avoiding legal liability by operating through third persons for whom they later deny all responsibility; the purpose is not to fix the scope of the authority of insurance agents. Mitchell v. Aetna Casualty & Surety Co., 579 F.2d 342, 1978 U.S. App. LEXIS 9253 (5th Cir. Miss. 1978).

This section does not apply so as to make the adjuster of a liability insurance company the agent of the insured. Southern Pine Superior Stud Corp. v. Herring, 207 So. 2d 632, 1968 Miss. LEXIS 1623 (Miss. 1968).

The insurance company which issued a major medical policy to the plaintiff was bound by the acts of the insurance agency with which the plaintiff dealt, where the insurer did not notify the plaintiff insured that the agency relationship between it and the local agency had been terminated. American Casualty Co. v. Whitehead, 206 So. 2d 838, 1968 Miss. LEXIS 1589 (Miss. 1968).

The word "adjust" means "settle" in the sense of paying. Napp v. Liberty Nat'l Life Ins. Co., 248 Miss. 320, 159 So. 2d 164, 1963 Miss. LEXIS 397 (Miss. 1963).

This section applies only to acts of insurance agents before and up to and including the consummation of the insurance and, after that, what takes place in the examination and adjustment of a loss, and as to all other matters and things, principles of the common law govern. Old Colony Ins. Co. v. Fagan Chevrolet Co., 246 Miss. 725, 150 So. 2d 172, 1963 Miss. LEXIS 498 (Miss. 1963).

The manifest purpose of this section is to enable the state to effectually supervise insurance companies and their agents. Saucier v. Life & Casualty Ins. Co., 189 Miss. 693, 198 So. 625, 1940 Miss. LEXIS 155 (Miss. 1940).

The statute making soliciting agent the agent of insurance company is in derogation of common law, and must not be extended beyond its intent and terms. Travelers' Fire Ins. Co. v. Price, 169 Miss. 531, 152 So. 889, 1934 Miss. LEXIS 49 (Miss. 1934).

Statute making soliciting agent the agent of insurance company held applicable only to acts of agent before and up to and including consummation of insurance, and acts of agent in examination and adjustment of loss. Travelers' Fire Ins. Co. v. Price, 169 Miss. 531, 152 So. 889, 1934 Miss. LEXIS 49 (Miss. 1934).

Statute of forum making proof of enumerated facts conclusive evidence of agency for insurer held in derogation of common law and inapplicable to case where insurer, its agents, and insured were residents of Tennessee and all essential acts were performed in such state. Interstate Life & Acci. Co. v. Pannell, 169 Miss. 50, 152 So. 635, 1934 Miss. LEXIS 13 (Miss. 1934).

2. Who are agents.

Where county obtained public officials liability insurance from insurance company through local, independent agent, which independent agent in turn contacted insurance wholesaler, which wholesaler dealt directly with insurance company, independent agent was insurance company's "agent" under Miss. Code Annotated § 83-17-1, as independent agent gave county blank application form for insurance and then sent completed form to insurance wholesaler for quotation, such that independent agent "took or transmitted" application to insurance company via insurance wholesaler, and after insurance company gave price quotation and forwarded it to insurance wholesaler, who forwarded it to independent agent, independent agent relayed quotation to county, thus performing "act or thing in the making" of insurance contract, and therefore independent agent was acting "on behalf of" or "for" insurance company, and county or covered employee could satisfy notice requirements of insurance policy by giving notice to either independent agent or insurance company. State v. Richardson, 817 F.2d 1203, 1987 U.S. App. LEXIS 6847 (5th Cir. Miss. 1987).

Where county purchased fidelity insurance from independent agent who in turn contacted insurance wholesaler that dealt directly with insurance company, independent agent was insurance company's "agent" under Mississippi law, as independent agent took or transmitted application to insurance company via insurance wholesaler and independent agent relayed premium charge quotation from insurance wholesaler to county, thus performing "act or thing in the making" of contract, such that independent agent advised county and was county's agent, and independent agent also acted "on behalf of" or "for" insurance company such that it was insurance company's agent under § 83-17-1, such that notice to independent agent constituted notice to insurance company. State v. Richardson, 817 F.2d 1203, 1987 U.S. App. LEXIS 6847 (5th Cir. Miss. 1987).

A local insurance soliciting agency which arranged insurance on a fleet of tractors was the agent of the insurer and the agent of the insurer's general agent for purposes of a suit by the insured against the insurer alleging improper failure to defend against a claim. Smith Trucking, Inc. v. Cotton Belt Ins. Co., 556 F.2d 1297, 1977 U.S. App. LEXIS 12129 (5th Cir. Miss. 1977).

In determining the status as an agent of an individual arranging insurance with an unauthorized insurer, § 83-17-1 was the appropriate section for determining agency where the sections listed in § 83-21-31 as particularly applicable to policies issued by unauthorized insurers did not refer to acts sufficient to constitute an agency relationship. Southeastern Fidelity Ins. Co. v. Gann, 340 So. 2d 429, 1976 Miss. LEXIS 1712 (Miss. 1976).

Where the local insurance agent, acting for the insurance company, not only advanced the premium to a general agent on the policy issued to a trucking company, but continued to make an effort to collect that company's check for the premium due on the policy, and, in fact, did pay the insurance company a portion of the premium when it was collected, the local agent acted for and as agent of the insurer. Soso Trucking, Inc. v. Central Ins. Agency, Inc., 236 So. 2d 398, 1970 Miss. LEXIS 1486 (Miss. 1970).

One soliciting insurance on behalf of the insurer, and who also prepared the application for insurance and transmitted it to the insurer, was the insurer's general agent, whose knowledge and information acquired in taking the policy was also the knowledge and information of the insurer. World Ins. Co. v. Bethea, 230 Miss. 765, 93 So. 2d 624, 1957 Miss. LEXIS 420 (Miss. 1957).

Cashier of branch office of insurance company who was authorized to transmit to home office applications for benefits under policies issued by company in state, and to advise policyholders of rights under policies and of proof necessary to sustain their claims, held "agent" of company within statute defining agent, as regards company's liability for disability benefits. Reliance Life Ins. Co. v. Cassity, 173 Miss. 840, 163 So. 508, 1935 Miss. LEXIS 266 (Miss. 1935).

Insurance company cannot escape effect of statute, declaring person delivering insurance policy insurer's agent, by allowing its sole agent to employ assistants to conduct business, including delivery of policies. Aetna Ins. Co. v. Lester, 170 Miss. 353, 154 So. 706, 1934 Miss. LEXIS 128 (Miss. 1934).

Defendant's acts in relation to fire policy held to bring them within statutory definition of insurance agents, making them personally liable upon policy, where insurance companies were unauthorized to do business in state. Wilkinson v. Goza, 165 Miss. 38, 145 So. 91, 1932 Miss. LEXIS 300 (Miss. 1932).

Insurer's agent who inspects risk, issues and delivers policy, and collects premium is "general agent" of insurer. St. Paul Fire & Marine Ins. Co. v. Loving, 163 Miss. 114, 140 So. 727, 1932 Miss. LEXIS 21 (Miss. 1932).

Person acting under instructions of another in procuring insurance for deceased through insurer's district manager held not insurer's agent as regards premium paid. Mutual Life Ins. Co. v. Tabb, 49 F.2d 1019, 1931 U.S. App. LEXIS 3301 (5th Cir. Miss. 1931).

An agent who delivers a policy and receives the premium is within the statute, and this is true whether agent was a soliciting or general agent. Big Creek Drug Co. v. Stuyvesant Ins. Co., 115 Miss. 333, 75 So. 768, 1917 Miss. LEXIS 185 (Miss. 1917).

3. Agents' powers, generally.

The general laws of agency apply to agency relationships in the insurance industry, and the powers possessed by agents of insurance companies are to be interpreted in accordance with such general laws. McPherson v. McLendon, 221 So. 2d 75, 1969 Miss. LEXIS 1483 (Miss. 1969).

An insurance adjuster does not have authority to extend the coverage of the policy to an expressly excluded liability, but the insurance company is estopped to deny his authority to adjust a loss within such coverage. Canal Ins. Co. v. Howell, 248 Miss. 678, 160 So. 2d 218, 1964 Miss. LEXIS 292 (Miss. 1964).

This section undertakes to designate as agent certain persons who in fact act for an insurance company in some particular, but it does not fix the scope of their authority as between the company and third persons, and certainly does not raise special agents, with limited authority, into general ones, possessing unlimited powers. Saucier v. Life & Casualty Ins. Co., 189 Miss. 693, 198 So. 625, 1940 Miss. LEXIS 155 (Miss. 1940).

The words "as to all the duties and liabilities imposed by law" ex vi termini refer not to duties and liabilities that grow out of the contract of insurance, such duties and liabilities being determined by the provisions of the contract itself, but to duties and liabilities imposed on insurance companies and their agents by law outside and independent of the provisions of the contract of insurance. Saucier v. Life & Casualty Ins. Co., 189 Miss. 693, 198 So. 625, 1940 Miss. LEXIS 155 (Miss. 1940); St. Paul Mercury & Indem. Co. v. Ritchie, 190 Miss. 8, 198 So. 741, 1940 Miss. LEXIS 182 (Miss. 1940).

One to whom insurance company's agent intrusted delivery of fire policy was insurer's agent. Aetna Ins. Co. v. Lester, 170 Miss. 353, 154 So. 706, 1934 Miss. LEXIS 128 (Miss. 1934).

The statute, while defining who is insurance agent, does not alter general law of agency. American Bankers' Ins. Co. v. Lee, 161 Miss. 85, 134 So. 836, 1931 Miss. LEXIS 249 (Miss. 1931).

4. Agents' knowledge as imputable to insurer; generally.

Insurer was not aware that there was a lienholder on an insured vehicle because, although knowledge acquired by a soliciting agent in the course of the agent's employment in soliciting insurance and preparing and transmitting applications was ordinarily imputed to the insurer, the agent never said that the agent was aware that there was a lienholder. Alexander v. Aig Agency Auto, Inc, 138 So. 3d 190, 2013 Miss. App. LEXIS 865 (Miss. Ct. App. 2013).

Life insurer could not avoid policy because the application for insurance did not fully disclose information given to its soliciting agents. National Life & Acci. Ins. Co. v. Miller, 484 So. 2d 329, 1985 Miss. LEXIS 2453 (Miss. 1985).

Where a local insurance agent, in the course of procuring the issuance by another agent of a collision insurance policy upon a motor truck, secured and transmitted to the issuing agent all necessary information relating to the ownership and description of the property to be insured, and later shared in that agent's commission, his knowledge relating to matters known to him prior to the issuance of the policy would be imputed to the company which insured the risk. American Fidelity Fire Ins. Co. v. Hancock, 186 So. 2d 212, 1966 Miss. LEXIS 1297 (Miss. 1966).

Issuance of renewal fire insurance policies by a general agent with knowledge of the vacancy and unoccupancy of the insured property waives the vacancy or unoccupancy clause. Travelers Fire Ins. Co. v. Bank of New Albany, 244 Miss. 788, 146 So. 2d 351, 1962 Miss. LEXIS 507 (Miss. 1962).

An insurance agent who, being unable to issue a fire insurance policy in his own company, procures insurance to be written by the agent of another company, is pro hac vice the agent of the latter company, so as to make his knowledge of other insurance imputable to it. Bankers Fire & Marine Ins. Co. v. Dungan, 240 Miss. 691, 128 So. 2d 544, 1961 Miss. LEXIS 498 (Miss. 1961).

Knowledge of general agent was also the knowledge of the insurer. World Ins. Co. v. Bethea, 230 Miss. 765, 93 So. 2d 624, 1957 Miss. LEXIS 420 (Miss. 1957).

Where insurer's defense to consolidated actions brought by an insured on two fire policies, which contained a clause that other insurance was prohibited unless the total amount of insurance was inserted on the first page of the policy, was that the insured had a third policy which was not mentioned in the first two policies, the knowledge of local agent who issued the policy would be imputed to the insurer. American Cent. Ins. Co. v. Meredith, 228 Miss. 402, 87 So. 2d 871, 1956 Miss. LEXIS 527 (Miss. 1956).

Insurance company held estopped to deny liability where agent knew that cotton insured was stored in framed sheds and not in brick compartments as stated in the policy. Agricultural Ins. Co. v. Anderson, 120 Miss. 278, 82 So. 146, 1919 Miss. LEXIS 87 (Miss. 1919); Saucier v. Life & Casualty Ins. Co., 189 Miss. 693, 198 So. 625, 1940 Miss. LEXIS 155 (Miss. 1940).

Knowledge of insurance company's agent was binding on insurer. Aetna Ins. Co. v. Lester, 170 Miss. 353, 154 So. 706, 1934 Miss. LEXIS 128 (Miss. 1934).

Knowledge of insurer's agent is knowledge of insurer. St. Paul Fire & Marine Ins. Co. v. Loving, 163 Miss. 114, 140 So. 727, 1932 Miss. LEXIS 21 (Miss. 1932).

Under this provision, knowledge acquired by insurer's soliciting agent in course of employment is ordinarily imputed to insurer. Hartford Fire Ins. Co. v. Clark, 154 Miss. 418, 122 So. 551, 1929 Miss. LEXIS 157 (Miss. 1929).

If this section was intended to make knowledge acquired by medical examiner for life company chargeable to insurer it is merely declaratory of common law. New York Life Ins. Co. v. Smith, 129 Miss. 544, 91 So. 456, 1922 Miss. LEXIS 8 (Miss. 1922).

Insurer cannot avoid policy because total insurance exceeds amount fixed by policy where agent procuring policies had knowledge of the facts. Stewart v. Coleman & Co., 120 Miss. 28, 81 So. 653, 1919 Miss. LEXIS 63 (Miss. 1919).

Agent delivering policy and receiving premium with knowledge that insured did not and had not under prior policy maintained an iron safe as stipulated, held to bind company and estop it from effecting forfeiture of the policy. Big Creek Drug Co. v. Stuyvesant Ins. Co., 115 Miss. 333, 75 So. 768, 1917 Miss. LEXIS 185 (Miss. 1917); Saucier v. Life & Casualty Ins. Co., 189 Miss. 693, 198 So. 625, 1940 Miss. LEXIS 155 (Miss. 1940).

5. —Notice to agent of claim or loss.

Under Mississippi law, notice of claim given to agent is imputed to insurance company, regardless of provisions in policy to the contrary. State v. Richardson, 817 F.2d 1203, 1987 U.S. App. LEXIS 6847 (5th Cir. Miss. 1987).

Notice of claim given to independent insurance agency is not to be imputed to insurance company by virtue of § 83-17-1, where (1) in securing policy, agency had dealt with insurance wholesaler and not with company itself, (2) agency does not have agency agreement with company and does not negotiate claims for company or deal directly with its personnel, (3) agency has acted more as advisor to insured than as agent of company, having provided other insurance to insured and having often provided advice to it on insurance matters. Mississippi ex rel. King v. Richardson, 634 F. Supp. 133, 1986 U.S. Dist. LEXIS 26924 (S.D. Miss. 1986), aff'd, 817 F.2d 1203, 1987 U.S. App. LEXIS 6847 (5th Cir. Miss. 1987).

Verbal notice of loss by insured to insurance agent through whom insurer issued policy constituted verbal notice to the insurer, despite the agent's failure to give actual notice to the insurer until a later time. Hood v. Fireman's Fund Ins. Co., 412 F. Supp. 846, 1976 U.S. Dist. LEXIS 15921 (S.D. Miss. 1976).

6. —Knowledge binding notwithstanding contrary provision in application or policy.

With regard to a claimant's request for life insurance benefits under a policy governed by the Employee Retirement Income Security Act of 1974, 29 U.S.C.S. § 1001 et seq., which the claimant purchased to insure her putative common law spouse, an agent's alleged knowledge that the claimant and the spouse was not legally married could be attributed to the insurer under Miss. Code Ann. § 83-17-1 for purposes of determining whether the insurer and plan administrator waived the plan's spousal eligibility requirement by accepting premium payments. Price v. Metro. Life Ins. Co., 2008 U.S. Dist. LEXIS 68063 (N.D. Miss. Sept. 8, 2008).

Under Mississippi law, notice given to agent is imputed to insurance company, regardless of provisions in policy to the contrary. State v. Richardson, 817 F.2d 1203, 1987 U.S. App. LEXIS 6847 (5th Cir. Miss. 1987).

Fire insurance company whose agent made out application and failed to write correcting applicant's answer to question held bound by answer notwithstanding contrary provision in application and policy. Home Ins. Co. v. Thornhill, 165 Miss. 787, 144 So. 861, 1932 Miss. LEXIS 297 (Miss. 1932); Saucier v. Life & Casualty Ins. Co., 189 Miss. 693, 198 So. 625, 1940 Miss. LEXIS 155 (Miss. 1940).

7. —Question of fact as to what agent knew.

In consolidated actions brought by an

insured on two fire policies which contain a clause that other insurance is prohibited unless the total amount of the insurance was inserted on the first page of the policy, where the insurer's defense was that the insured had a third policy which was not mentioned in the first two policies, it was an issue of fact for the determination of the jury whether the local agent who issued the two policies knew of the existence of the third policy. American Cent. Ins. Co. v. Meredith, 228 Miss. 402, 87 So. 2d 871, 1956 Miss. LEXIS 527 (Miss. 1956).

8. —Agent's exercise of discretion in determining insurability.

Insurance agent's knowledge of credit life insurance applicant's prior heart attack is imputable to insurer and agent's decision to extend insurance coverage to applicant binds insurer where agent is given no definite guidelines for determining who is or is not insurable party and it is agent's understanding, corroborated by superiors in company, that agent is to use own discretion in deciding who qualifies for insurance; insurance company which refuses to pay claim under such circumstances is subject to punitive damages. Southern United Life Ins. Co. v. Caves, 481 So. 2d 764, 1985 Miss. LEXIS 2452 (Miss. 1985).

9. Agents' act or statements as binding insurer—generally.

The evidence was sufficient to support a jury finding that agents for a life insurer had the apparent authority to form an immediate binding contract with certain insureds where admissions were made by an executive and an agent of the insurer, there was a blatant failure by the insurer to provide "notice of restrictions upon [the agents'] authority" to avert misleading or fraudulent misrepresentations, and the insureds were not afforded an opportunity to become properly informed through inspection of sample policies, brochures, "or anything," and discover that the agents' offers "wrongfully" contravened unrevealed policy conditions. Andrew Jackson Life Ins. Co. v. Williams, 566 So. 2d 1172, 1990 Miss. LEXIS 435 (Miss. 1990).

A limitation upon the authority of a general insurance agent, having power to make contracts of insurance, would not relieve the insurer from liability on a policy issued by such agent in violation of the limitation, where the insured had neither actual nor constructive notice of such limitation, and the insurer had taken no step to give notice to the public that the agent's authority was so limited. McPherson v. McLendon, 221 So. 2d 75, 1969 Miss. LEXIS 1483 (Miss. 1969).

Where a general agent used a form designed by the insurer for use as a memorandum of an existing policy and transformed it into a binder of insurance by the insertion of a typewritten statement at the top of the document, the binder was effective as insurance. Cummings v. New England Ins. Co., 266 F.2d 888, 1959 U.S. App. LEXIS 5191 (5th Cir. Miss. 1959).

The words "as to all the duties and liabilities imposed by law," contained herein, were not effective to enlarge the authority of an insurance adjuster to cover medical and hospital expense in the settlement of a personal injury claim under an employer's liability policy in excess of a specific limitation thereon contained in the policy, in view of a provision therein against charge, waiver, alteration, or extension of any of the agreements, conditions or declarations contained in the policy except by specific officers of the insurance company. St. Paul Mercury & Indem. Co. v. Ritchie, 190 Miss. 8, 198 So. 741, 1940 Miss. LEXIS 182 (Miss. 1940).

A mutual life and disability company, which has been converted from a fraternal society, was, under this section [Code 1942, § 5706], bound by the act of its agent in misleading the insured as to the extent of disability necessary to entitle him to file a claim therefor, since upon its conversion it ceased to be a fraternal society entitled to the immunity provided by Code of 1930, § 5234, [Code 1942, § 5748], applicable to fraternal societies. Columbian Mut. Life Ins. Co. v. Gipson, 185 Miss. 890, 189 So. 799, 1939 Miss. LEXIS 192 (Miss. 1939).

Where insured, on requesting insurer's agent to supply forms for filing of claim for total disability, was informed that eligibility for such benefits depended on insured's being forever disabled, and insured, who expressed hope of recovery, abandoned effort to collect disability benefits, wife could recover such benefits after insured's death where it appeared that insured was totally disabled when he applied for application blanks for filing of claim. Reliance Life Ins. Co. v. Cassity, 173 Miss. 840, 163 So. 508, 1935 Miss. LEXIS 266 (Miss. 1935).

One to whom insurance company's agent intrusted delivery of fire policy was insurer's agent, whose statements at time of delivery were binding on insurer. Aetna Ins. Co. v. Lester, 170 Miss. 353, 154 So. 706, 1934 Miss. LEXIS 128 (Miss. 1934).

Life insurance agent's statement, contrary to policy, that insurer was liable from inception of disability and that insured would not lose anything because she had failed to make due proof sooner, held mere expressions of opinion without effect upon policy by virtue of this statute. Mutual Life Ins. Co. v. Hebron, 166 Miss. 145, 146 So. 445, 1933 Miss. LEXIS 344 (Miss. 1933).

Agreement of agent to renew vacancy permit held to bind company and to entitle insured to recover for loss during time permit was to be renewed and while house was vacant. Sutherland v. Federal Ins. Co., 97 Miss. 345, 52 So. 689, 1910 Miss. LEXIS 259 (Miss. 1910).

10. —Premiums.

Payment of premium to agent effects payment to insurance company. Barhonovich v. American Nat'l Ins. Co., 947 F.2d 775, 1991 U.S. App. LEXIS 27953 (5th Cir. Miss. 1991).

In action by insured against insurer for negligence, breach of contract, and conversion, based on acts of insurance agent converting plaintiff's premiums, insurance company was not guilty of negligence in failing to credit plaintiff's account, failing to handle his policy properly, or allowing him to remain uninsured for over 2 years, where it did not authorize, consent, encourage or ratify agent's fraudulent activities, nor authorize agent to falsify premium documentation, divert plaintiff's premiums, or misrepresent to plaintiff that he was no longer required to pay premiums. Barhonovich v. American Nat'l Ins. Co., 947 F.2d 775, 1991 U.S. App. LEXIS 27953 (5th Cir. Miss. 1991).

An insurance company cannot insist upon collecting premiums on an insurance policy and, at the same time, successfully contend that the insurance policy had been cancelled for nonpayment of premiums. Soso Trucking, Inc. v. Central Ins. Agency, Inc., 236 So. 2d 398, 1970 Miss. LEXIS 1486 (Miss. 1970).

Where a check is accepted as payment for insurance premiums and not accepted for collection by an insurance agent, the transaction is equivalent to payment, and this is true although the check is not paid when first presented to the bank. Soso Trucking, Inc. v. Central Ins. Agency, Inc., 236 So. 2d 398, 1970 Miss. LEXIS 1486 (Miss. 1970).

It has been accepted as a general rule of law that where credit has been given by the general agent of an insurer for the premiums on an insurance policy, the transaction is equivalent to payment. Soso Trucking, Inc. v. Central Ins. Agency, Inc., 236 So. 2d 398, 1970 Miss. LEXIS 1486 (Miss. 1970).

Where the proof showed that the insured paid the premiums on a major medical policy to the agent from whom he purchased the policy, and he was at no time notified either by the agent or the insurer that his policy had lapsed because of failure to pay premiums or that the local agent's contract had been terminated by the insurer, the defense of nonpayment of premiums was not available to the insurer seeking to avoid payment of a claim under the policy. American Casualty Co. v. Whitehead, 206 So. 2d 838, 1968 Miss. LEXIS 1589 (Miss. 1968).

An insurance adjuster does not have authority to extend the coverage of the policy to an expressly excluded liability, but the insurance company is estopped to deny his authority to adjust a loss within such coverage. Canal Ins. Co. v. Howell, 248 Miss. 678, 160 So. 2d 218, 1964 Miss. LEXIS 292 (Miss. 1964).

This section does not raise a local insurance agent, with limited powers, to such an agent as had authority to deliver, and establish the company's liability for, a life insurance policy without payment of the initial premium in violation of the terms of the policy contract. Saucier v. Life & Casualty Ins. Co., 189 Miss. 693, 198 So. 625, 1940 Miss. LEXIS 155 (Miss. 1940).

This provision does not make binding upon the insurer a soliciting agent's alleged extension of time for payment of annual installment of note executed for premiums due on five-year fire policy, which provided that insurer should not be liable for loss occurring while insured was in default. Aetna Ins. Co. v. Singleton, 174 Miss. 556, 164 So. 13, 1935 Miss. LEXIS 57 (Miss. 1935).

11. —Waiver.

An agent had apparent authority to issue a credit life insurance policy in excess of the master policy limits, and therefore his actions in issuing such a policy were binding on the insurance company, where the insurance company furnished the agent with blank certificates of insurance bearing the insurance company logo, the agent regularly issued policies of credit life insurance through the insurance company using these forms, and the agent had previously issued policies in excess of the master policy limits on several occasions. Malta Life Ins. Co. v. Estate of Washington, 552 So. 2d 827, 1989 Miss. LEXIS 435 (Miss. 1989).

Insurance company was not bound by its agent informing individual and his wife that individual was insured where there was no indication of detrimental reliance on agent's statement by individual and his wife, thus failing to establish one of elements of apparent authority necessary under general law of agency. Ford v. Lamar Life Ins. Co., 513 So. 2d 880, 1987 Miss. LEXIS 2708 (Miss. 1987).

Insurance agent's knowledge of credit life insurance applicant's prior heart attack is imputable to insurer and agent's decision to extend insurance coverage to applicant binds insurer where agent is given no definite guidelines for determining who is or is not insurable party and it is agent's understanding, corroborated by superiors in company, that agent is to use own discretion in deciding who qualifies for insurance; insurance company which refuses to pay claim under such circumstances is subject to punitive damages. Southern United Life Ins. Co. v. Caves, 481 So. 2d 764, 1985 Miss. LEXIS 2452 (Miss. 1985).

Issuance of renewal fire insurance policies by a general agent, with knowledge of the vacancy and unoccupancy of the insured property, waives the vacancy or unoccupancy clause. Travelers Fire Ins. Co. v. Bank of New Albany, 244 Miss. 788, 146 So. 2d 351, 1962 Miss. LEXIS 507 (Miss. 1962).

A local agent of an insurance company furnished with blank forms to be filled out, countersigned, and issued by him has all the powers of a general agent when issuing policies, and can waive any of the policy provisions. American Cent. Ins. Co. v. Meredith, 228 Miss. 402, 87 So. 2d 871, 1956 Miss. LEXIS 527 (Miss. 1956); Liverpool & London & Globe Ins. Co. v. Delaney, 190 Miss. 404, 200 So. 440, 1941 Miss. LEXIS 57 (Miss. 1941).

The agent who has authority to fill out, sign, and deliver an insurance policy, and especially for a foreign insurance company with whom the applicant for insurance has no dealings other than through such agent, has all the powers of a general agent of the company when issuing such policy and may waive any of their provisions. Camden Fire Ins. Ass'n v. Koch, 216 Miss. 576, 63 So. 2d 103, 1953 Miss. LEXIS 671 (Miss. 1953).

There was a waiver of provisions in insurance policy that an assignment should not be valid except with the written consent of insurers, where the jury found on sufficient evidence that purchaser requested general agent of insurers to transfer insurance to him, and agent informed purchaser that insurance would be transferred, but insurance was never transferred and property was destroyed by fire without purchaser obtaining other insurance. Camden Fire Ins. Ass'n v. Koch, 216 Miss. 576, 63 So. 2d 103, 1953 Miss. LEXIS 671 (Miss. 1953).

Where an agent made a mistake in writing a fire and windstorm insurance policy in that he failed to insert in the policy the correct amount of premium necessary for the coverage included in it, and the company failed to detect the error, and also it was not shown that there was any scheme fraudulent or otherwise for a rebate of a portion of the premium, the policies were not void. Queen Ins. Co. v. Delta Gin Co., 210 Miss. 167, 48 So. 2d 866, 1950 Miss. LEXIS 332 (Miss. 1950).

If an insurance company's agent was advised of the existence of another insurance policy on the house insured, which was for the determination of the jury, the stipulation in the policy that it would be void if the house covered by it was or would become covered by another insurance policy was waived, by the agent's issuing the policy notwithstanding stipulations to the contrary therein. Liverpool & London & Globe Ins. Co. v. Delaney, 190 Miss. 404, 200 So. 440, 1941 Miss. LEXIS 57 (Miss. 1941).

In Scottish Union & Nat. Ins. Co. v. Wylie (1915) 110 Miss 681, 70 So 835, it was held that an insurance agent might bind the insurer by a waiver of non-insurance and non-mortgage clauses in a policy. Scottish Union & Nat'l Ins. Co. v. Wylie, 110 Miss. 681, 70 So. 835, 1915 Miss. LEXIS 104 (Miss. 1915).

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Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

Fraud or misrepresentation by insured's agent after loss as within provision avoiding policy for fraud or attempted fraud of insured. 24 A.L.R.2d 1220.

Misrepresentation by one other than insurance agent as to coverage, exclusion, or legal effect of insurance policy, as actionable. 29 A.L.R.2d 213.

Insured's responsibility for false answers inserted by insurer's agent in application following correct answers by insured, or incorrect answers suggested by agent. 26 A.L.R.3d 6.

Insurer's tort liability for acts of adjuster seeking to obtain settlement or release. 39 A.L.R.3d 739.

Insurance agents or salesmen as within coverage of social security or unemployment compensation acts. 39 A.L.R.3d 872.

Liability of insurance broker or agent to insured for failure to procure insurance. 64 A.L.R.3d 398.

Liability of insurance agent or broker on ground of inadequacy of liability insurance coverage procured. 72 A.L.R.3d 704.

Liability of insurance agent or broker on ground of inadequacy of life, health, and accident insurance coverage procured. 72 A.L.R.3d 735.

Liability of insurance agent or broker on ground of inadequacy of property insurance coverage procured. 72 A.L.R.3d 747.

Activities of insurance adjusters as unauthorized practice of law. 29 A.L.R.4th 1156.

Necessity or permissibility of naming no-fault insurer as defendant where insured automobile owner or operator is not liable for economic losses under no-fault insurance law. 40 A.L.R.4th 858.

Liability of insurance agent or broker to insured for misrepresentation of cash surrender value or accumulated value benefits of life insurance policy. 44 A.L.R.4th 1030.

Liability of insurer, or insurance agent or adjuster, for infliction of emotional distress. 6 A.L.R.5th 297.

Liability of insurance agent or broker for placing insurance with insolvent carrier. 42 A.L.R.5th 199.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 170 et seq.

12A Am. Jur. Pl & Pr Forms (Rev), Fright, Shock, and Mental Disturbance, Form 44 (complaint, petition, or declaration-by widow-for damages resulting from intentional infliction of mental distress-threats and misrepresentations by insurance adjuster to force compromise of claim).

10 Am. Jur. Legal Forms 2d, Insurance §§ 149:73 et seq. (agency agreements).

23 Am. Jur. Proof of Facts 2d 527, Fraud of Insurer in Inducement or Execution of Contract.

31 Am. Jur. Proof of Facts 2d 323, Insurer's Breach of Covenant of Good Faith and Fair Dealing-First-Party Claims.

10 Am. Jur. Proof of Facts 3d 579, Insurance Agent's or Broker's Failure to Process Insurance.

CJS.

44 C.J.S., Insurance §§ 198, 199 et seq.

Law Reviews.

1978 Mississippi Supreme Court Review: Insurance. 50 Miss. L. J. 97.

1981 Mississippi Supreme Court Review: Insurance. 52 Miss. L. J. 445.

Walter & Cory, The Circumvention of Mississippi's Prohibition of Direct Actions, 66 Miss L.J. 493.

Practice References.

Business Insurance Law and Practice Guide, (Matthew Bender).

Business Law Monographs, Volume IN1 —Business Uses of Life Insurance (Matthew Bender Elite Products).

Business Law Monographs, Volume IN2 —Casualty and Liability Insurance (Matthew Bender).

§ 83-17-3. Personal liability.

An insurance agent shall be personally liable on all contracts of insurance unlawfully made by or through him, directly or indirectly, for or in behalf of any company not authorized to do business in the state.

HISTORY: Codes, 1906, § 2616; Hemingway's 1917, § 5079; 1930, § 5197; 1942, § 5707.

Cross References — Liability of agent for evaluation of property for fire insurance, see § 83-13-5.

Liability of agent for issuing policy under assessment plan, see § 83-25-3.

Penalty for acting as agent of company not complying with law, see § 97-23-31.

JUDICIAL DECISIONS

1. In general.

Defendant insurance agent's was personally liable as a matter of law under Miss. Code §§ 83-17-3, 83-17-103 (repealed Jan. 1, 2002), for insurance policies which he "helped place" with a company that was not licensed to sell insurance within the state, where documented communication that reflects the agent was involved in passing information, including an insurance proposal, between plaintiffs and the non-licensed company that resulted in a policy being issued. Home Health Care Affiliates of Miss., Inc. v. N. Am. Indem. N.V., 299 F. Supp. 2d 645, 2004 U.S. Dist. LEXIS 5933 (N.D. Miss. 2004).

Defendant insurance agent's motion for summary judgment was denied where the statutory language of Miss. Code §§ 83-17-3, 83-17-103 (repealed Jan. 1, 2002), assigned him liability for plaintiffs' renewal policy even though he argued was not directly involved in the renewal. Home Health Care Affiliates of Miss., Inc. v. N. Am. Indem. N.V., 299 F. Supp. 2d 645, 2004 U.S. Dist. LEXIS 5933 (N.D. Miss. 2004).

Agreement between an employer and an insurance agent for group health insurance coverage was regulated by state insurance laws and not preempted by ERISA; the agent was liable under Miss. Code Ann. § 83-17-3 for approved, unpaid claims because the insurer was not authorized to do business in the state. Home Healthcare Affiliates of Miss., Inc. v. Am. Heartland Health Adm'rs, Inc., 2003 U.S. Dist. LEXIS 25204 (N.D. Miss. Mar. 21, 2003).

Statute making agent personally liable if agent writes coverage for company not authorized to do business in state did not apply to policy issued by automobile insurer that was authorized for personal lines, not commercial business; statute says nothing about writing coverage insurance company is not authorized to provide. Dixie Ins. Co. v. Mooneyhan, 684 So. 2d 574, 1996 Miss. LEXIS 57 (Miss. 1996).

This statute must be considered along with Code 1972 § 83-21-27, which permits specially licensed agents to place insurance with non-admitted companies without assuming personal liability. Goff v. Dixon, 311 So. 2d 642, 1975 Miss. LEXIS 1615 (Miss. 1975).

Statute imposing personal liability, on

policy, on agent of insurance company unauthorized to do business in state held not in abridgment of privilege of contract. Wilkinson v. Goza, 165 Miss. 38, 145 So. 91, 1932 Miss. LEXIS 300 (Miss. 1932).

Statute making insurance agent, of company unauthorized to do business in state, personally liable on policy held remedial, not penal, and insured's suit thereunder was not within one-year limitation. Wilkinson v. Goza, 165 Miss. 38, 145 So. 91, 1932 Miss. LEXIS 300 (Miss. 1932).

Defendants' acts in relation to fire policy held to bring them within statutory definition of insurance agents, making them personally liable upon policy, where insurance companies were unauthorized to do business in state. Wilkinson v. Goza, 165 Miss. 38, 145 So. 91, 1932 Miss. LEXIS 300 (Miss. 1932).

RESEARCH REFERENCES

ALR.

Liability of insurance broker or agent to insured for failure to procure insurance. 64 A.L.R.3d 398.

Liability of insurance agent or broker on ground of inadequacy of liability insurance coverage procured. 72 A.L.R.3d 704.

Liability of insurance agent or broker on ground of inadequacy of life, health, and accident insurance coverage procured. 72 A.L.R.3d 735.

Liability of insurance agent or broker on ground of inadequacy of property insurance coverage procured. 72 A.L.R.3d 747.

Liability of insurance agent or broker to insured for misrepresentation of cash surrender value or accumulated value benefits of life insurance policy. 44 A.L.R.4th 1030.

Liability of independent or public insurance adjuster to insured for conduct in adjusting claim. 50 A.L.R.4th 900.

Necessity of expert testimony to show standard of care in negligence action against agent or broker. 52 A.L.R.4th 1232.

Liability of tortfeasor's insurance agent or broker to injured party for failure to procure or maintain liability insurance. 72 A.L.R.4th 1095.

Liability of insurance agent or broker for placing insurance with insolvent carrier. 42 A.L.R.5th 199.

Am. Jur.

14A Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 386.1 (complaint, petition or declaration-allegation-malice or fraud of insurer).

10 Am. Jur. Proof of Facts 3d 579, Insurance Agent's or Broker's Failure to Process Insurance.

CJS.

44 C.J.S., Insurance § 251.

§ 83-17-5. Agent certificate; notification of nonrenewal required.

Every agent of any insurance company, fraternal order or association authorized to do business in this state shall be required to obtain from the Commissioner of Insurance a certificate under the seal of his office showing that the company for which he or she is licensed to do business in this state, and that he or she is an agent of said company and duly authorized to do business for it. Such certificate shall remain valid as long as the insurance company, fraternal order or association pays to the commissioner an annual certificate fee to continue the authorization. The insurance company, fraternal order or association must notify the agent within thirty (30) days if the authority is nonrenewed or cancelled.

HISTORY: Codes, 1906, § 2627; Hemingway's 1917, § 5093; 1930, § 5198; 1942, § 5708; Laws, 1988, ch. 526, § 5; Laws, 1990, ch. 355, § 2; Laws, 2003, ch. 419, § 1; Laws, 2006, ch. 314, § 1, eff from and after July 1, 2006.

Editor's Notes — Section 13 of ch. 526, Laws, 1988, provides as follows:

"SECTION 13. The commissioner may, after notice and hearing, issue rules and regulations that he deems necessary to effectuate the purposes of this act or to eliminate devices or plans designed to avoid or render ineffective the provisions of this act. The commissioner may require such information as is reasonably necessary for the enforcement of this act. All rules and regulations adopted and promulgated pursuant to this act shall be subject to the provisions of the Mississippi Administrative Procedures Law as provided in Section 25-43-1 et seq. [now 25-43-1.101 et seq.], Mississippi Code of 1972."

Cross References — Privilege taxes on insurance agents, see §§ 27-15-85 et seq.

Authority to issue continuous agent certificates, see § 83-15-3.

Use of facsimile countersignatures when authorization is given by agent in writing to insurer for which agent is certified to do business pursuant to this section, see § 83-17-21.

Procedure for organizing insurance company, see § 83-19-11.

Delivery of insurance policies through resident agents, see § 83-31-37.

Privilege tax for continuous agent certificate, see § 83-37-21.

JUDICIAL DECISIONS

1. In general.

Insurer cannot defeat recovery on policy on ground that agent failed to comply with this section [Code 1942, § 5708]. Caledonian Fire Ins. Co. v. Shepherd, 111 Miss. 175, 71 So. 314, 1916 Miss. LEXIS 263 (Miss. 1916).

RESEARCH REFERENCES

ALR.

Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

Am. Jur.

43 Am. Jur. 2d, Insurance § 75.

CJS.

44 C.J.S., Insurance § 138.

§ 83-17-7. Commission to unauthorized agent unlawful; employees or authorized agents of limited license rental car company may receive commission under rental car company's limited license.

(1) It shall be unlawful for any insurance company or any insurance agent to pay, directly or indirectly, any commission, brokerage or other valuable consideration on account of any policy or policies written on risks in this state to any person, agent, firm or corporation not duly licensed as an insurance agent in this state, except that property and other risks of nonresident persons, and of foreign corporations not qualified in this state, may be insured by brokers or other agents duly licensed in other states.

It shall be lawful, however, for an insurance company or any insurance agent to pay, directly or indirectly, to the surviving spouse or heirs of a deceased licensed insurance agent in this state any commissions or other valuable consideration to which the deceased agent would be entitled, whether such surviving spouse or heir is or is not a licensed agent.

It shall be lawful for an insurance agent, agency or affiliate to pay a referral fee to any unlicensed employee of the agent, agency or affiliate when the employee refers a prospective insured to the licensed agent or agency. The referral fee shall be a one-time nominal fee of a fixed dollar amount for each referral customer. The payment of any referral fee shall not depend on whether the referral results in a sale of any insurance products. Furthermore, the referral fee shall not be based on a percentage of any premiums or commissions collected by the licensed agent. The referral fee shall not be paid, either directly or indirectly, to the prospective insured.

(2) Notwithstanding any provision in this section to the contrary, employees and authorized agents of a limited license rental car company:

(a) May receive compensation for activities under the rental car company's limited license that is incidental to their overall compensation, including, but not limited to, commissions, bonuses and other valuable consideration;

(b) May offer, sell or solicit, in connection with and incidental to the rental of rental cars, the kinds of insurance specified in Section 83-17-63(1)(h) under the limited license of the rental car company; and

(c) Shall not require any additional licensing under this chapter or any other provision of Title 83 relating to paragraph (a) or (b) above.

(3) The Commissioner of Insurance may promulgate rules and regulations necessary to carry out the provisions of this section.

HISTORY: Codes, 1942, § 5710; Laws, 1938, ch. 194; Laws, 1975, ch. 372; Laws, 1999, ch. 474, § 1; Laws, 2001, ch. 433, § 3; Laws, 2006, ch. 315, § 1; Laws, 2010, ch. 419, § 2; Laws, 2015, ch. 364, § 1, eff from and after July 1, 2015.

Cross References — Agents for foreign insurance company, see § 83-21-7.

Agents for reciprocal insurance contracts, see § 83-33-3.

JUDICIAL DECISIONS

1. In general.

Payment of dividends from distributable earnings by a corporate agency, even though such earnings might derive from commissions paid to the agency, would not be in violation of this section. Johnson & Higgins, Inc. v. Commissioner of Ins., 321 So. 2d 281, 1975 Miss. LEXIS 1519 (Miss. 1975).

RESEARCH REFERENCES

ALR.

Insurance agent's right to commissions on renewal premiums. 36 A.L.R.3d 958.

Am. Jur.

43 Am. Jur. 2d, Insurance § 200.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 101 (complaint, petition, or declaration-breach of contract between brokers to share commission on sale of insurance policy and to assign right to renewal commissions).

CJS.

44 C.J.S., Insurance § 138.

§§ 83-17-9 and 83-17-11. Repealed.

Repealed by Laws, 2001, ch. 510, § 34, eff from and after January 1, 2002.

§ 83-17-9. [Codes, 1942, § 5711; Laws, 1938, ch. 194.]

§ 83-17-11. [Codes, 1942, § 5712; Laws, 1938, ch. 194; Laws, 2000, ch. 417, § 1.]

Editor's Notes — Former § 83-17-9 was entitled "Agents of other states."
Former § 83-17-11 was entitled "Penalty for paying unauthorized agent."

§ 83-17-13. Penalty for signing blank policy.

It shall be unlawful for any agent of a fire insurance company, or of any other insurance company which is required to have its policies signed by a resident agent, to sign any blank policy of insurance. Upon satisfactory proof that any agent has violated the provisions of this section, the commissioner shall revoke such agent's license for all companies for not less than three (3) nor more than six (6) months for the first offense, and for one (1) year for the second offense.

HISTORY: Codes, 1906, § 2654; Hemingway's 1917, § 5120; 1930, § 5200; 1942, § 5713; Laws, 1938, ch. 194.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 77.

CJS.
44 C.J.S., Insurance § 138.

§§ 83-17-15 and 83-17-17. Repealed.

Repealed by Laws, 2001, ch. 510, § 34, eff from and after January 1, 2002.

§ 83-17-15. [Codes, 1942, § 5714; Laws, 1938, ch. 194.]

§ 83-17-17. [Codes, 1906, § 2657; Hemingway's 1917, § 5123; Laws, 1930, § 5203; Laws, 1942, § 5717; Laws, 2001, ch. 510, § 34.]

Editor's Notes — Former § 83-17-15 was entitled "Application of statute."
Former § 83-17-17 was entitled "Penalty for acting as adjuster without license."

§ 83-17-19. Penalty for soliciting without license.

Every person who, either as principal or agent or pretending to be such, shall solicit, examine, or inspect any risk, or shall examine into, adjust, or aid in adjusting any loss, or shall receive, collect, or transmit any premiums of insurance, or shall do any other act in the soliciting, making, or executing of any contract of insurance of any kind otherwise than this chapter permits shall be deemed guilty of a misdemeanor and, on conviction, shall pay a fine of not less than Two Hundred Dollars ($200.00) nor more than Five Hundred Dollars ($500.00), or be imprisoned not less than one (1) nor more than two (2) years, or both, in the discretion of the court.

HISTORY: Codes, 1906, § 2658; Hemingway's 1917, § 5124; 1930, § 5204; 1942, § 5718.

Cross References — Certificate of authority for insurance agent, see § 83-17-5.
Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

RESEARCH REFERENCES

ALR.

Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

Recovery back of money paid to unlicensed person required by law to have occupation or business license or permit to make contract. 74 A.L.R.3d 637.

CJS.

44 C.J.S., Insurance § 138.

§ 83-17-21. Policies to be written through licensed agents.

No fire, fire marine, accident, health, employers' liability, steam boiler, plate glass, fidelity, surety, burglary, or other insurance company except life insurance companies, not incorporated under the laws of this state authorized to transact business herein shall make, write, place, or cause to be made, written, or placed any policy, duplicate policy, or contract of insurance of any kind or character or any general or floating policy upon persons or property in this state, except after the risk has been approved, in writing, by an agent, regularly commissioned and licensed to transact insurance business herein, who shall countersign all policies or contracts of insurance so issued. The provisions of this section shall not apply to individual firms and corporations indemnifying themselves through reciprocal contracts, and not employing local agents. No provision of this section is intended, or shall be so intended, as to direct insurance covering the rolling stock of railroad corporations, or property in transit while in the possession and custody of railroad corporations or other common carriers. The written approval and countersignature of licensed agents may be in facsimile when used solely in connection with personal accident insurance covering travel, issued through the medium of policy dispensing machines; however, land travel insurance so issued may not be issued for a period longer than seven (7) days from the date of issue. The written approval and countersignature of licensed agents may also be in facsimile when authorization is given by the agent in writing to an insurer for which the agent is certified to do business pursuant to Section 83-17-5. The use of facsimile countersignatures shall not modify any of the other requirements of this section. Any authorization for a facsimile countersignature may be canceled by the agent in writing and is automatically canceled upon the death, termination or nonrenewal of the agent.

HISTORY: Codes, Hemingway's 1917, § 5147; 1930, § 5205; 1942, § 5719; Laws, 1916, ch. 205; Laws, 1948, ch. 350, § 1; Laws, 1962, ch. 465; Laws, 1970, ch. 452, § 1; Laws, 1991, ch. 393, § 1; Laws, 1999, ch. 344, § 1, eff from and after July 1, 1999.

Cross References — Agents for reciprocal insurance contracts, see § 83-33-3.

Comparable Laws from other States — Georgia Code Annotated, § 33-23-16. Louisiana Revised Statutes Annotated, § 22:982.

JUDICIAL DECISIONS

1. In general.

This section deals specifically with insurance companies not incorporated under the laws of this state, and was inapplicable where the applicant for a license to operate as an incorporated agency had already been incorporated under the statutes of this state. Johnson & Higgins, Inc. v. Commissioner of Ins., 321 So. 2d 281, 1975 Miss. LEXIS 1519 (Miss. 1975).

RESEARCH REFERENCES

ALR.

Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

Am. Jur.

43 Am. Jur. 2d, Insurance § 89.

CJS.

44 C.J.S., Insurance § 138.

§ 83-17-23. Repealed.

Repealed by Laws, 2001, ch. 510, § 34, eff from and after January 1, 2002.

§ 83-17-23. [Codes, 1906, § 2653; Hemingway's 1917, § 5119; Laws, 1930, § 5206; Laws, 1942, § 5720.]

Editor's Notes — Former § 83-17-23 was entitled "Foreign companies to operate through resident agents."

§ 83-17-25. Duration of privilege licenses.

No certificate of authority shall be issued to any agent who has not previously obtained from the commissioner a privilege license to act as an insurance agent; provided that agents or organizers of fraternal orders shall not be required to have such privilege license.

The privilege license of an individual to act as an insurance producer, limited lines producer, limited lines credit insurance producer, supervising general agent or managing general agent shall continue from the date of issuance of original licenses or from the expiration date for existing licenses until the last day of the month of the licensee's birthday in the second year following issuance or renewal of the license, with a minimum term of thirteen (13) months.

The privilege license of a business entity to act as insurance producer, limited lines producer, limited lines credit insurance producer, supervising general agent or managing general agent shall continue from the date of issuance until May 31 in the second year following issuance or renewal of the license, with a minimum term of thirteen (13) months.

HISTORY: Codes, 1906, § 2633; Hemingway's 1917, § 5099; 1930, § 5207; 1942, § 5721; Laws, 1956, ch. 340; Laws, 1995, ch. 315, § 2; Laws, 2009, ch. 448, § 6, eff from and after Nov. 1, 2009; Laws, 2022, ch. 473, § 4, eff from and after July 1, 2022.

Amendment Notes —
The 2022 amendment deleted the former second and third paragraphs, which related to the duration of privilege licenses and filing fees required of life insurance, health and accident insurance, hospital insurance, and fraternal insurance companies, and privilege licenses and filing fees required of fire, casualty, liability, fidelity, surety, guaranty, inland marine, plate glass and title insurance companies.

Cross References — Privilege taxes on insurance agents, see §§ 27-15-85 et seq.

Renewal of privilege licenses granted to supervising general agents, see § 27-15-89.

JUDICIAL DECISIONS

1. Suspension of license.

When a contractor sued insurers and their agent for negligently issuing a bid bond without authority, due to expiration of the agent's certificate for failure to pay a renewal fee, summary judgment erred because the agent was unauthorized to issue the bond, which had to be valid on the date issued but was null and void, and a later payment of the fee and reinstatement of the agent did not retroactively validate the bond, so fact questions existed as to the negligent issuance of the bond contrary to a duty to the contractor. King Metal Bldgs., Inc. v. Renasant Ins., Inc., 159 So. 3d 567, 2014 Miss. App. LEXIS 377 (Miss. Ct. App. 2014), cert. denied, 158 So. 3d 1153, 2015 Miss. LEXIS 142 (Miss. 2015).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 75.

CJS.
44 C.J.S., Insurance § 138.

§§ 83-17-27 through 83-17-35. Repealed.

Repealed by Laws, 2001, ch. 510, § 34, eff from and after January 1, 2002.
§ 83-17-27. [Codes, 1942, § 5630.7; Laws, 1966, ch. 529, §§ 1-4.]
§ 83-17-29. [Codes, 1942, § 5723-11; Laws, 1962, ch. 469, § 1.]
§ 83-17-31. [Codes, 1942, § 5723-12; Laws, 1962, ch. 469, § 2.]
§ 83-17-33. [Codes, 1942, § 5723-13; Laws, 1962, ch. 469, § 3.]
§ 83-17-35. [Codes, 1942, § 5723-14; Laws, 1962, ch. 469, § 4.]

Editor's Notes — Former § 83-17-27 was entitled "Publication of agents directory."
Former § 83-17-29 was entitled "Unauthorized counselling and advising prohibited."
Former § 83-17-31 was entitled "Notice and hearing."
Former § 83-17-33 was entitled "Penalties for unauthorized counselling."
Former § 83-17-35 was entitled "Appeals."

§ 83-17-37. Expiration of license; application for renewal.

(1) Each license issued to a producer shall expire on the mandated renewal date following the date of issue, unless prior thereto it is revoked or suspended by the commissioner.

(2) Each producer shall file an application for renewal of license on the

form and in the manner prescribed by the commissioner for such purpose. Upon the filing of such application for renewal of license and the payment of the required fees, the current license shall continue to be in force until the renewal license is issued by the commissioner or until the commissioner has refused for cause to issue such renewal license, as provided in Section 83-17-71, and has given notice of such refusal in writing to the producer.

HISTORY: Laws, 2001, ch. 510, § 21, eff from and after Jan. 1, 2002.

§ 83-17-39. Examination of applicants; classification of applicants; textbooks and learning materials.

(1) Each applicant for a license to act as a producer within this state shall submit to a personal written examination to determine his competence to act as a producer and his familiarity with the pertinent provisions of the laws of this state, and shall pass the same to the satisfaction of the commissioner; except that no such written examination shall be required of:

(a) An applicant for a renewal license unless the commissioner determines that such examination is necessary to establish the competency of the applicant, or unless a license had not been effective as to such applicant within one (1) year preceding the date of filing the application;

(b) An applicant who is a ticket-selling agent of a railroad or steamship company, carrier by air, or public bus carrier who shall act as a producer or solicitor in the sale of accident insurance tickets to individuals;

(c) An applicant who shall be licensed to act only as a producer with respect to life, health and accident insurance on borrowers or debtors commonly known as credit life, health and accident insurance;

(d) In the discretion of the commissioner, an applicant whose license to do business or act as a producer in this state was suspended less than one (1) year prior to the date of application;

(e) An applicant who is an agent of a fraternal benefit society exclusively;

(f) An applicant who is exempt from examination under the provisions of Section 83-17-67; and

(g) An applicant who shall be licensed to act only as a producer with respect to property insurance on borrowers or debtors commonly known as credit property insurance.

(2) The commissioner may establish rules and regulations with respect to the classification of applicants according to the type of insurance contracts to be effected by them if licensed as producers, and with respect to the scope, type and conduct of written examinations to be given pursuant to this section, and the times and places within this state for the holding of such examinations. Such rules and regulations, if established, shall classify applicants for purposes of this section as follows:

(a) Those desiring to write life insurance;

(b) Those desiring to write accident and health insurance, other than industrial accident and health insurance;

(c) Those desiring to write industrial accident and health insurance;

(d) Those desiring to write any combination of two (2) or more of the above classifications; and

(e) Those of such other classification as, in the opinion of the commissioner, are necessary or appropriate.

Examination shall be prepared and given in those subjects only which pertain to the classification or classifications which the applicant desires to write, and no applicant shall be required to take an examination on a subject or subjects pertaining to any other classification.

The rules and regulations of the commissioner, if established, shall designate textbooks, manuals and other materials to be studied by applicants in preparation for examination in each classification designated by the commissioner pursuant to this section. Such textbooks, manuals or other materials may consist of matter available to applicants by purchase from the publisher, or may consist of matter prepared at the direction of the commissioner and distributed to applicants upon request therefor and payment of the reasonable cost thereof. If textbooks, manuals or other materials shall have been designated or prepared by the commissioner pursuant to this section, all examination questions shall be prepared from the contents of such textbooks, manuals or other materials.

HISTORY: Laws, 2001, ch. 510, § 22; Laws, 2006, ch. 318, § 1, eff from and after passage (approved Mar. 1, 2006).

§ 83-17-41. Licensing by type or kind of insurance; sanctions for selling type or kind of insurance for which not properly licensed.

The commissioner may, from time to time, make reasonable groupings into type, types or kinds of insurance that may be lawfully written in this state, for the purpose of prescribing reasonable written examinations for producer and solicitor licenses for each group respectively, and for the issuance of limited licenses. Any such licensed producer or solicitor who shall attempt to write any type of business or seek a brokerage commission on a type of business for which he is not properly licensed and authorized shall, after investigation of all circumstances and proper notice of hearing, be subject to hearing for revocation or suspension of the license.

HISTORY: Laws, 2001, ch. 510, § 23, eff from and after Jan. 1, 2002.

§ 83-17-43. Repealed.

Repealed by Laws of 2009, ch. 448, § 17, effective November 1, 2009.

§ 83-17-43. [Laws, 2001, ch. 510, § 24, eff from and after Jan. 1, 2002.]

Editor's Notes — Former § 83-17-43 required the filing of a Certificate of Appointment.

§ 83-17-45. Prohibited acts; liability.

(1) No producer or other persons shall, within this state, solicit, procure, receive or forward applications for insurance or annuities, or issue or deliver policies for, or in any manner secure, help, or aid in the placing of any contract of insurance or annuity for any person other than himself, directly or indirectly, with any insurer not authorized to do business in this state.

(2) Any producer or any other person who violates the provisions of this section shall be liable for the full amount of any loss sustained on any contract of life, health or accident insurance or annuity made by or through him, directly or indirectly, with any insurer not authorized to do business in this state and, in addition, for any premium taxes which may become due under any law of this state by reason of such contract.

HISTORY: Laws, 2001, ch. 510, § 25, eff from and after Jan. 1, 2002.

§ 83-17-47. Commissioner's subpoena power.

The Commissioner of Insurance shall have the power to administer oaths and affirmations, issue subpoenas and order the attendance and testimony of witnesses and the production of papers, books and documents. Upon the failure of any person to comply with any subpoena or order issued under the authority of this section, the Commissioner of Insurance may invoke the aid of any court of the state of general jurisdiction. The court thereupon may order such person to comply with the requirements of the subpoena or order to give evidence touching the matter in question. Failure to obey the order of the court may be punished by the court as a contempt thereof.

HISTORY: Laws, 2001, ch. 510, § 26, eff from and after Jan. 1, 2002.

ARTICLE 2.

LICENSING OF INSURANCE PRODUCERS.

Sec.
83-17-51. Purpose and scope of article.
83-17-53. Definitions.
83-17-55. License required to sell, solicit or negotiate insurance; requirements for issuing license to partnerships; employees or authorized agents of limited license rental car company may offer, sell or solicit certain insurance under limited license of rental car company.
83-17-57. Exemptions from licensing requirement.
83-17-59. Examination.
83-17-61. Application requirements.
83-17-63. Qualification for license in certain lines of authority; license to remain in effect absent revocation, suspension, or failure to pay annual fee; reinstatement and renewal; waiver of renewal requirements due to extenuating circumstances; information to be included on license; change of address.
83-17-64. Limited license as insurance producer for self-storage insurance; definitions; employee or representative of licensee may act on behalf of licensee under certain circumstances.

Sec.
83-17-65. Nonresident licenses.
83-17-67. Individuals licensed in another state; exemption from prelicensing education or examination; 90-day application deadline.
83-17-69. Temporary license.
83-17-71. Violations; penalties; judicial review; funding of agency expenses; deposit of monies into State General Fund.
83-17-73. Licensing required before individual may accept commission for selling; employees or authorized agents of limited license rental car company may receive commission under rental car company's limited license.
83-17-75. Appointment of producer as agent of insurer.
83-17-77. Notification of termination of insurance business relationship; termination procedure; immunity from civil liability absent actual malice; confidential and privileged information.
83-17-79. Reciprocity.
83-17-81. Producer to report to commissioner any administrative or criminal action initiated against producer.
83-17-83. Appellate review.
83-17-85. Inquisitorial and subpoena power of commissioner.
83-17-87. Regulations.
83-17-89. Severability.

§ 83-17-51. Purpose and scope of article.

The purpose of this article is to provide the qualifications and procedures required for the licensing of insurance producers. This article does not apply to excess and surplus lines agents and brokers licensed under Sections 83-21-17 through 83-21-31 except as provided in Sections 83-17-65 and 83-17-79(2), or to domestic title insurance companies and their agents licensed under Sections 83-15-1 through 83-15-11, except as provided in Section 83-17-75.

HISTORY: Laws, 2001, ch. 510, § 1, eff from and after Jan. 1, 2002.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in a statutory reference. The reference to "83-17-77(e)" was changed to "83-17-79(2)." The Joint Committee ratified the correction at its June 3, 2003, meeting.

RESEARCH REFERENCES

Practice References.
New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-17-53. Definitions.

The following words and phrases shall have the meanings ascribed herein unless the context clearly indicates otherwise:

(a) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

(b) "Commissioner" means the Commissioner of Insurance.

(c) "Home state" means the District of Columbia and any state or territory of the United States in which an insurance producer maintains his or her principal place of residence or principal place of business and is licensed to act as an insurance producer.

(d) "Insurance" means any of the lines of authority in Section 83-19-1.

(e) "Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance.

(f) "Insurer" means that as defined in Section 83-6-1.

(g) "License" means a document issued by the commissioner authorizing a person to act as an insurance producer for the lines of authority specified in the document. The license itself does not create any authority, actual, apparent or inherent, in the holder to represent or commit an insurance carrier.

(h) "Limited line credit insurance" includes credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection (gap) insurance and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the commissioner determines should be designated a form of limited line credit insurance.

(i) "Limited line credit insurance producer" means a person who sells, solicits or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group or individual policy.

(j) "Limited lines insurance" means those lines of insurance defined in Section 83-19-1, Class 1(b), (e), (p) and (q) and Section 83-19-1, Class 2(d), Section 83-17-63 (1)(h), (i), (j), (k) and (*l*), or any other line of insurance that the commissioner deems necessary to recognize for the purposes of complying with Section 83-17-65(5).

(k) "Limited lines producer" means a person authorized by the commissioner to sell, solicit or negotiate limited lines insurance.

(*l*) "Negotiate" means the act of conferring directly with or offering advice directly to a purchaser or prospective purchaser of a particular contract of insurance concerning any of the substantive benefits, terms or conditions of the contract, if the person engaged in that act either sells insurance or obtains insurance from insurers for purchasers.

(m) "Person" means an individual or a business entity.

(n) "Sell" means to exchange a contract of insurance by any means, for money or its equivalent, on behalf of an insurance company.

(o) "Solicit" means attempting to sell insurance or asking or urging a person to apply for a particular kind of insurance from a particular company.

(p) "Terminate" means the cancellation of the relationship between an insurance producer and the insurer or the termination of a producer's authority to transact insurance.

(q) "Uniform business entity application" means the current version of the NAIC uniform business entity application for resident and nonresident business entities.

(r) "Uniform application" means the current version of the NAIC uniform application for resident and nonresident producer licensing.

HISTORY: Laws, 2001, ch. 510, § 2; Laws, 2009, ch. 448, § 7, eff from and after Nov. 1, 2009; Laws, 2019, ch. 324, § 1, eff from and after July 1, 2019.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in a statutory reference. The reference in (j) to "Section 8(5) of this act" was changed to "Section 83-17-65(5)." The Joint Committee ratified the correction at its June 3, 2003, meeting.

§ 83-17-55. License required to sell, solicit or negotiate insurance; requirements for issuing license to partnerships; employees or authorized agents of limited license rental car company may offer, sell or solicit certain insurance under limited license of rental car company.

(1) A person shall not sell, solicit or negotiate insurance in this state for any class or classes of insurance unless the person is licensed for that line of authority in accordance with this article.

(2) No license shall be issued to a partnership unless all the partners thereof satisfy the same requirements in every respect for an individual producer provided for in this article.

(3) Notwithstanding any provision in this section to the contrary, employees and authorized agents of a limited license rental car company:

(a) May receive compensation for activities under the rental car company's limited license that is incidental to their overall compensation, including, but not limited to, commissions, bonuses and other valuable consideration;

(b) May offer, sell or solicit, in connection with and incidental to the rental of rental cars, the kinds of insurance specified in Section 83-17-63(1)(h) under the limited license of the rental car company; and

(c) Shall not require any additional licensing under this chapter or any other provision of Title 83 relating to paragraph (a) or (b) above.

HISTORY: Laws, 2001, ch. 510, § 3; Laws, 2015, ch. 364, § 2, eff from and after July 1, 2015.

§ 83-17-57. Exemptions from licensing requirement.

(1) Nothing in this article shall be construed to require an insurer to obtain an insurance producer license. In this section, the term "insurer" does not include an insurer's officers, directors, employees, subsidiaries or affiliates.

(2) A license as an insurance producer shall not be required of the following:

(a) An officer, director or employee of an insurer or of an insurance producer, if the officer, director or employee does not receive any commission on policies written or sold to insure risks residing, located or to be performed in this state and:

(i) The officer, director or employee's activities are executive, administrative, managerial, clerical or a combination of these and are only indirectly related to the sale, solicitation or negotiation of insurance; or

(ii) The officer, director or employee's function relates to underwriting, loss control or inspection of insurance; or

(iii) The officer, director or employee is acting in the capacity of a special agent or agency supervisor assisting insurance producers where the person's activities are limited to providing technical advice and assistance to licensed insurance producers and do not include the sale, solicitation or negotiation of insurance;

(b) A person who secures and furnishes information for the purpose of group life insurance, group property and casualty insurance, group annuities, group or blanket accident and health insurance or for the purpose of enrolling individuals under plans or issuing certificates under plans or otherwise assisting in administering plans; or who performs administrative services related to mass marketed property and casualty insurance where no commission is paid to the person for the service;

(c) An employer or association or its officers, directors, employees, or the trustees of an employee trust plan, to the extent that the employers, officers, employees, directors or trustees are engaged in the administration or operation of a program of employee benefits for the employer's or association's own employees or the employees of its subsidiaries or affiliates, which program involves the use of insurance issued by an insurer, as long as the employers, associations, officers, directors, employees or trustees are not in any manner compensated, directly or indirectly, by the company issuing the contracts;

(d) Employees of insurers or organizations employed by insurers who are engaging in the inspection, rating or classification of risk or in the supervision of the training of insurance producers and who are not individually engaged in the sale, solicitation or negotiation of insurance;

(e) A person whose activities in this state are limited to advertising without the intent to solicit insurance in this state through communications in printed publications or other forms of electronic mass media whose distribution is not limited to residents of the state, if the person does not sell, solicit or negotiate insurance that would insure risks residing, located or to be performed in this state;

(f) A person who is not a resident of this state who sells, solicits or negotiates a contract of insurance for commercial property and casualty risks to an insured with risks located in more than one (1) state insured under that contract, if that person is otherwise licensed as an insurance producer to sell, solicit or negotiate that insurance in the state where the insured maintains its principal place of business and the contract of insurance insures risks located in that state; or

(g) A salaried full-time employee who counsels or advises his or her employer relative to the insurance interests of the employer or of the subsidiaries or business affiliates of the employer if the employee does not sell or solicit insurance or receive a commission.

HISTORY: Laws, 2001, ch. 510, § 4, eff from and after Jan. 1, 2002.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected an error in the first sentence of (2)(c). The word "officers" was substituted for "officer" and the word "directors" was substituted for "director." The Joint Committee ratified the correction at its August 5, 2008, meeting.

§ 83-17-59. Examination.

(1) A resident individual applying for an insurance producer license shall pass a written examination unless exempt under Section 83-17-67 or Section 83-17-39. The examination shall test the knowledge of the individual concerning the lines of authority for which application is made, the duties and responsibilities of an insurance producer and the insurance laws and regulations of this state. Examinations required by this section shall be developed and conducted under rules and regulations prescribed by the commissioner.

(2) The commissioner may make arrangements, including contracting with an outside testing service, for administering examinations and collecting a nonrefundable examination fee.

(3) Each individual applying for an examination shall remit a nonrefundable fee as prescribed by the commissioner.

(4) An individual who fails to appear for the examination as scheduled or fails to pass the examination shall reapply for an examination and remit all required fees and forms before being rescheduled for another examination.

HISTORY: Laws, 2001, ch. 510, § 5, eff from and after Jan. 1, 2002.

§ 83-17-61. Application requirements.

(1) A person applying for a resident insurance producer license shall make application to the commissioner on the uniform application and declare under penalty of refusal, suspension or revocation of the license that the statements made in the application are true, correct and complete to the best of the individual's knowledge and belief. Before approving the application, the commissioner shall find that the individual:

(a) Is at least eighteen (18) years of age;

(b) Has not committed any act that is a ground for denial, suspension or revocation set forth in Section 83-17-71;

(c) Where required by the commissioner, has completed a prelicensing course of study for the lines of authority for which the person has applied;

(d) Has paid the fees set forth in Section 27-15-87; and

(e) Has successfully passed the examinations for the liens of authority for which the person has applied.

(2) A business entity acting as an insurance producer is required to obtain an insurance producer license. Application shall be made using the uniform

business entity application. Before approving the application, the commissioner shall find that:

(a) The business entity has paid the fees set forth in Section 27-15-85; and

(b) The business entity has designated a licensed producer responsible for the business entity's compliance with the insurance laws, rules and regulations of this state.

(3) The commissioner may require any documents reasonably necessary to verify the information contained in an application.

(4) Each insurer that sells, solicits or negotiates any form of limited line credit insurance shall provide to each individual whose duties include selling, soliciting or negotiating limited line credit insurance a program of instruction that may be approved by the commissioner.

HISTORY: Laws, 2001, ch. 510, § 6; Laws, 2009, ch. 448, § 19, eff from and after Nov. 1, 2009.

§ 83-17-63. Qualification for license in certain lines of authority; license to remain in effect absent revocation, suspension, or failure to pay annual fee; reinstatement and renewal; waiver of renewal requirements due to extenuating circumstances; information to be included on license; change of address.

(1) Unless denied licensure under Section 83-17-71, persons who have met the requirements of Sections 83-17-59 and 83-17-61, shall be issued an insurance producer license. An insurance producer may receive qualification for a license in one or more of the following lines of authority:

(a) Life: insurance coverage on human lives, including benefits of endowment and annuities and may include benefits in the event of death or dismemberment by accident and benefits for disability income.

(b) Accident and health or sickness: insurance coverage for sickness, bodily injury or accidental death and may include benefits for disability income.

(c) Property: insurance coverage for the direct or consequential loss or damage to property of every kind.

(d) Casualty: insurance coverage against legal liability, including that for death, injury or disability or damage to real or personal property.

(e) Variable life and variable annuity products: insurance coverage provided under variable life insurance contracts and variable annuities.

(f) Personal lines: property and casualty insurance coverage sold to individuals and families for primarily noncommercial purposes.

(g) Credit: limited line credit insurance.

(h)(i) Car rental: limited line insurance offered, sold or solicited in connection with and incidental to the rental of rental cars, whether at the rental office or preselection of coverage in master, corporate or individual agreements that is nontransferrable, applies only to the rental car that is the subject of the rental agreement and is limited to the following kinds of insurance:

1. Personal accident insurance for renters and other rental car occupants, for accidental death or dismemberment, and for medical expenses resulting from an accident that occurs with the rental car during the rental period;

2. Liability insurance that provides protection to the renters and other authorized drivers of a rental car for liability arising from the operation or use of the rental car during the rental period;

3. Personal effects insurance that provides coverage to renters and other vehicle occupants for loss of, or damage to, personal effects in the rental car during the rental period;

4. Roadside assistance and emergency sickness protection insurance; or

5. Any other coverage designated by the Commissioner of Insurance.

(ii) Notwithstanding anything in this section or any other provision of law to the contrary, employees and authorized agents of a limited license rental car company:

1. May receive compensation for activities under the rental car company's limited license that is incidental to their overall compensation, including, but not limited to, commissions, bonuses and other valuable consideration;

2. May offer, sell or solicit, in connection with and incidental to the rental of rental cars, the kinds of insurance specified in this paragraph (h) under the limited license of the rental car company; and

3. Shall not require any additional licensing under this chapter or any other provision of Title 83 relating to item 1 or 2 of this subparagraph (ii).

(iii) Each limited license rental car company shall conduct a training program for its employees and authorized agents in which the employees and authorized agents being trained shall receive basic instruction about the kinds of insurance specified in this paragraph (h). Once its employees and authorized agents have been trained, each limited license rental car company shall provide supervision for these employees and authorized agents relating to their offer to, sale to, or solicitation of prospective renters of rental cars with respect to the kinds of insurance specified in this paragraph (h).

(i) Crop insurance: limited line insurance providing protection against damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease or other yield-reducing conditions or perils provided by the private insurance market, or that is subsidized by the Federal Crop Insurance Corporation, including Multi-Peril Crop Insurance.

(j) Surety: limited line insurance or bond that covers obligations to pay the debts of, or answer for the default of another, including faithlessness in a position of public or private trust. For purpose of limited line licensing, surety does not include Surety Bail Bonds.

(k) Travel: limited line insurance coverage for trip cancellation, trip interruption, baggage, life, sickness and accident, disability and personal effects when limited to a specific trip and sold in connection with transportation provided by a common carrier.

(*l*) Self-storage: limited line insurance coverage for the loss or damage to personal property that occurs at a self-storage facility or when such property is in transit to or from a self-storage facility during the period of a rental agreement.

(m) Any other line of insurance permitted under state laws or regulations.

(2) An insurance producer license shall remain in effect unless revoked or suspended as long as the fee set forth in Section 27-15-87 is paid and education requirements for resident individual producers are met by the due date.

(3) An individual insurance producer who allows his or her license to lapse may, within twelve (12) months from the due date of the renewal fee, reinstate the same license without the necessity of passing a written examination. The penalty for such late renewal shall be in compliance with Section 27-15-215.

(4) A licensed insurance producer who is unable to comply with license renewal procedures due to military service or some other extenuating circumstances, including, but not limited to, a long-term medical disability may request a waiver of those procedures. The producer may also request a waiver of any examination requirement or any other fine or sanction imposed for failure to comply with renewal procedures.

(5) The license shall contain the licensee's name, address, personal identification number and the date of issuance, the lines of authority, the expiration date and any other information the commissioner deems necessary.

(6) Licensees shall inform the commissioner by any means acceptable to the commissioner of a change of address within thirty (30) days of the change. Failure to timely inform the commissioner of a change in legal name or address shall result in a penalty under Section 83-17-71.

(7) In order to assist in the performance of the commissioner's duties, the commissioner may contract with nongovernmental entities, including the National Association of Insurance Commissioners (NAIC) or any affiliates or subsidiaries that the NAIC oversees, to perform any ministerial functions, including the collection of fees, related to producer licensing that the commissioner and the nongovernmental entity may deem appropriate.

HISTORY: Laws, 2001, ch. 510, § 7; Laws, 2002, ch. 322, § 1; Laws, 2009, ch. 448, § 8; Laws, 2015, ch. 364, § 3, eff from and after July 1, 2015; Laws, 2019, ch. 324, § 2, eff from and after July 1, 2019.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in subsection (1)(h) by substituting "whether at the rental office or preselection of coverage" for "whether at the rental office of preselection of coverage." The Joint Committee ratified the correction at its July 22, 2010, meeting.

Cross References — Penalty for failure to procure license, see § 27-15-215.

RESEARCH REFERENCES

Practice References.
Business Law Monographs, Volume IN2—Casualty and Liability Insurance (Matthew Bender).

§ 83-17-64. Limited license as insurance producer for self-storage insurance; definitions; employee or representative of licensee may act on behalf of licensee under certain circumstances.

(1) For purposes of this section, the following terms have the following meanings unless the context clearly indicates otherwise. Any terms defined in Section 85-7-121 shall have the meaning provided therein unless otherwise defined in this section.

(a) "Limited lines producer" means an individual or business entity authorized and licensed by the commissioner to offer, sell, solicit and negotiate self-storage insurance.

(b) "Occupant" means a person, his sublessee, successor or assign entitled to the use of a leased space at a self-storage facility under a rental agreement to the exclusion of others.

(c) "Owner" means the owner, operator, lessor or sublessor of a self-storage facility, an agent or any person authorized to manage the facility or to receive rent from an occupant under a rental agreement. The term "owner" shall not be construed to mean a warehouseman unless the owner issues a warehouse receipt, bill of lading or other document of title for the personal property stored.

(d) "Personal property" means any movable property not affixed to land including, but not limited to, goods, wares, merchandise, motor vehicles, watercraft, and household items and furnishings.

(e) "Rental agreement" means any written agreement or lease that establishes or modifies the terms, conditions, rules or any other provisions concerning the use and occupancy of a self-storage facility.

(f) "Self-storage facility" means a business entity that offers individual storage space to nonresident occupants who are to have their own means of access to the facility at any time for the purpose of storing and removing personal property.

(g) "Self-storage insurance" means personal property insurance offered in connection with and incidental to the lease or rental of leased space at a self-storage facility and that provides coverage to occupants for the loss of or damage to personal property that occurs at the self-storage facility or when such property is in transit to or from the self-storage facility during the period of the rental agreement.

(h) "Supervising entity" means a business entity that is a licensed insurer or insurance producer that is authorized by an insurer to supervise the administration of a self-storage insurance program.

(2) The commissioner may issue to an individual or business entity that has filed with the commissioner an application for such limited license in a form and manner prescribed by the commissioner, a limited lines self-storage insurance producer license which authorizes the limited lines producer to offer, sell, solicit and negotiate insurance through a licensed insurer at each location where the limited lines producer conducts business.

(3) A limited lines producer may authorize any employee or representative of the licensee to act individually on behalf and under the supervision of the licensee to offer, sell, solicit and negotiate self-storage insurance under the limited lines producer's license and without the need for an individual producer's license only if the following conditions are met:

(a) The limited lines producer complies with the provisions of Section 83-17-61(2). The designated responsible licensed producer required in Section 83-1-61(2)(b), Mississippi Code of 1972, need not be an employee or owner of the self-storage facility.

(b) Written or electronic materials containing the following information must be made readily available to the purchasers of the self-storage insurance:

(i) A description of the material terms or the actual material terms of the insurance coverage;

(ii) A description of the process for filing a claim;

(iii) A description of the review or cancellation process for the insurance coverage;

(iv) A disclosure that the insurance coverage may provide a duplication of coverage already provided by an existing policy of insurance;

(v) A statement that the purchase by the occupant of the insurance coverage offered by the limited lines producer is not required in order to enter into a rental agreement; and

(vi) The identity and contact information of the insurer and limited lines producer.

(c) At the time of licensure, the limited lines producer shall establish and maintain a register on a form prescribed by the commissioner of each self-storage facility that offers insurance on the limited lines producer's behalf. The register shall be maintained and updated by the limited lines producer and shall include the name, address and contact information of the self-storage facility and an officer or person who directs or controls the facility's operations. The limited lines producer shall submit such register to the Department of Insurance (department) upon reasonable request.

(d) A self-storage facility employee or authorized representative, who is not licensed as an insurance producer, may not:

(i) Evaluate or interpret the technical terms, benefits and conditions of the offered insurance coverage;

(ii) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(iii) Claim to be a licensed insurer, licensed producer, or insurance expert.

(e) The insurer issuing the self-storage insurance either directly supervises or authorizes a supervising entity to supervise the administration of the program including development of a training program for employees and authorized representatives of the limited lines producer. The training required by this paragraph shall comply with the following:

(i) The training shall be delivered to employees and authorized representatives of the limited lines producer who are directly engaged in the activity of selling, soliciting or negotiating self-storage insurance;

(ii) The training may be provided in electronic form. However, if conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding the self-storage insurance that is conducted and overseen by licensed employees of the supervising entity;

(iii) Each employee and authorized representative shall receive basic instruction about the self-storage insurance offered by the limited lines producer and the disclosures required under subsection (3)(b) of this section; and

(iv) The training shall include provisions required under any rules and regulations promulgated by the department.

(4) Notwithstanding any other provision in law, an owner is authorized to receive compensation for billing and collection services. Limited lines producers shall not be required to maintain the funds from the sale of self-storage insurance in a segregated or trust account, provided that the limited lines producer is authorized by the insurer or supervising entity to hold the funds in an alternative manner and remits such amounts to the insurer or supervising entity within sixty (60) days of receipt. All premiums for self-storage insurance received by a limited lines producer, or any employee or representative of that producer, from an occupant shall be considered funds held in a fiduciary capacity for the benefit of the insurer.

(5) Self-storage insurance may be provided under an individual policy or under a group, corporate or master policy.

(6) The limited lines producer shall be subject to the provisions of Sections 83-5-29 through 83-5-51 and Section 83-17-71.

(7) An owner is not required to be licensed under this section solely to display and make available to occupants and prospective occupants brochures and other promotional materials created by or on behalf of an authorized insurer or a surplus lines insurer.

(8) It shall be unlawful for any owner or employee of a self-storage facility, or any limited lines producer, or employee or representative of that producer, to require the purchase of insurance coverage offered by the owner or limited lines producer to enter into a rental agreement.

HISTORY: Laws, 2019, ch. 324, § 3, eff from and after July 1, 2019.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected an error in an internal statutory reference by substituting "Section 83-17-61(2)(b)" for "Section 83-1-61(2)(b)" in subsection (3)(a). The Joint Committee ratified the correction at its August 12, 2019, meeting.

§ 83-17-65. Nonresident licenses.

(1) Unless denied licensure pursuant to Section 83-17-71, a nonresident person shall receive a nonresident producer license if:

(a) The person is currently licensed as a resident and is in good standing in his or her home state;

(b) The person has submitted the proper request for licensure and has paid the fees required by Section 27-15-87;

(c) The person has submitted or transmitted to the commissioner the application for licensure that the person submitted to his or her home state, or a completed uniform application; and

(d) The person's home state awards nonresident producer licenses to residents of this state on the same basis.

(2) The commissioner may verify the producer's licensing status through the producer database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

(3) A nonresident producer who moves from one (1) state to another state or a resident producer who moves from this state to another state shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application is required.

(4) Notwithstanding any other provision of this article, a person licensed as a surplus lines producer in his or her home state shall receive a nonresident surplus lines producer license in accordance with subsection (1) of this section. Except as to subsection (1) of this section, nothing in this section otherwise amends or supersedes any provision of Sections 83-21-17 through 83-21-31.

(5) Notwithstanding any other provision of this article, a person licensed as a limited line credit insurance or other type of limited lines producer in his or her home state shall receive a nonresident limited lines producer license in accordance with subsection (1) of this section, granting the same scope of authority as granted under the license issued by the producer's home state. For the purposes of this subsection, limited line insurance is any authority granted by the home state which restricts the authority of the license to less than the total authority prescribed in the associated major lines under Section 83-17-63(1)(a) through (f).

(6) Notwithstanding any other provision of this article to the contrary, a person licensed in this state as a nonresident producer whose license is denied, suspended or revoked in his or her home state shall also have his or her nonresident license denied, suspended or revoked in this state without prior notice or hearing. The commissioner shall notify the nonresident producer, by United States regular mail sent to the nonresident producer's last-known address on file at the Insurance Department, that the nonresident producer's license has been denied, suspended or revoked. The nonresident producer may

within ten (10) days of the date of the letter make written request to the department for hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing shall be held within thirty (30) days of the receipt of the written request.

HISTORY: Laws, 2001, ch. 510, § 8; Laws, 2009, ch. 448, § 20; Laws, 2016, ch. 305, § 2, eff from and after July 1, 2016.

§ 83-17-67. Individuals licensed in another state; exemption from prelicensing education or examination; 90-day application deadline.

(1) An individual who applies for an insurance producer license in this state who was previously licensed for the same lines of authority in another state shall not be required to complete any prelicensing education or examination. This exemption is only available if the person is currently licensed in that state or if the application is received within ninety (90) days of the cancellation of the applicant's previous license and if the prior state issues a certification that, at the time of cancellation, the applicant was in good standing in that state or the state's producer database records, maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries, indicate that the producer is or was licensed in good standing for the line of authority requested.

(2) A person licensed as an insurance producer in another state who moves to this state shall make application within ninety (90) days of establishing legal residence to become a resident licensee in accordance with Section 83-17-61. No prelicensing education or examination shall be required of that person to obtain any line of authority previously held in the prior state except where the commissioner determines otherwise by regulation.

HISTORY: Laws, 2001, ch. 510, § 9, eff from and after Jan. 1, 2002.

§ 83-17-69. Temporary license.

(1) The commissioner may issue a temporary insurance producer license for a period not to exceed one hundred eighty (180) days without requiring an examination if the commissioner deems that the temporary license is necessary for the servicing of an insurance business in the following cases:

(a) To the surviving spouse or court-appointed personal representative of a licensed insurance producer who dies or becomes mentally or physically disabled to allow adequate time for the sale of the insurance business owned by the producer or for the recovery or return of the producer to the business or to provide for the training and licensing of new personnel to operate the producer's business.

(b) To a member or employee of a business entity licensed as an insurance producer, upon the death or disability of an individual designated in the business entity application or the license;

(c) To the designee of a licensed insurance producer entering active service in the Armed Forces of the United States of America; or

(d) In any other circumstance where the commissioner deems that the public interest will best be served by the issuance of this license.

(2) The commissioner may by order limit the authority of any temporary licensee in any way deemed necessary to protect insureds and the public. The commissioner may require the temporary licensee to have a suitable sponsor who is a licensed producer or insurer and who assumes responsibility for all acts of the temporary licensee and may impose other similar requirements designed to protect insureds and the public. The commissioner may by order revoke a temporary license if the interest of insureds or the public are endangered. A temporary license may not continue after the owner or the personal representative disposes of the business.

HISTORY: Laws, 2001, ch. 510, § 10, eff from and after Jan. 1, 2002.

§ 83-17-71. Violations; penalties; judicial review; funding of agency expenses; deposit of monies into State General Fund.

(1) The commissioner may place on probation, suspend, revoke or refuse to issue or renew an insurance producer's license or may levy a civil penalty in an amount not to exceed One Thousand Dollars ($1,000.00) per violation and such penalty shall be deposited into the special fund of the State Treasury designated as the "Insurance Department Fund" for any one or more of the following causes:

(a) Providing incorrect, misleading, incomplete or materially untrue information in the license application;

(b) Violating any insurance laws, or violating any regulation, subpoena or order of the commissioner or of another state's commissioner;

(c) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(d) Improperly withholding, misappropriating or converting any monies or properties received in the course of doing insurance business;

(e) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(f) Having been convicted of a felony;

(g) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

(h) Using fraudulent, coercive or dishonest practices or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

(i) Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(j) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(k) Improperly using notes or any other reference material to complete an examination for an insurance license;

(*l*) Knowingly accepting insurance business from an individual who is not licensed;

(m) Failing to comply with an administrative or court order imposing a child support obligation; or

(n) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

(2) If the action by the commissioner is to nonrenew or to deny an application for a license, the commissioner shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the commissioner within ten (10) days for a hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing shall be held within thirty (30) days.

(3) The license of a business entity may be suspended, revoked or refused if the commissioner finds, after hearing, that an individual licensee's violation was known or should have been known by one or more of the partners, officers or managers acting on behalf of the partnership or corporation and the violation was neither reported to the commissioner nor corrective action taken.

(4) In addition to, or in lieu of, any applicable denial, suspension or revocation of a license, a person may, after hearing, be subject to a civil fine not to exceed One Thousand Dollars ($1,000.00) per violation and such fine shall be deposited into the special fund in the State Treasury designated as the "Insurance Department Fund."

(5) The commissioner shall retain the authority to enforce the provisions of and impose any penalty or remedy authorized by this article and Title 83, Mississippi Code of 1972, against any person who is under investigation for or charged with a violation of this article or Title 83, Mississippi Code of 1972, even if the person's license or registration has been surrendered or has lapsed by operation of law.

(6) No licensee whose license has been revoked hereunder shall be entitled to file another application for a license as a producer within one (1) year from the effective date of such revocation or, if judicial review of such revocation is sought, within one (1) year from the date of final court order or decree affirming such revocation. Such application, when filed, may be refused by the commissioner unless the applicant shows good cause why the revocation of his license shall not be deemed a bar to the issuance of a new license.

(7) Notwithstanding any other provision of this article to the contrary, a person licensed in this state as a nonresident producer whose license is denied, suspended or revoked in his or her home state shall also have his or her nonresident license denied, suspended or revoked in this state without prior notice or hearing.

(8) From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

(9) From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Laws, 2001, ch. 510, § 11; Laws, 2016, ch. 305, § 3; Laws, 2016, ch. 459, § 29, eff from and after July 1, 2016.

Joint Legislative Committee Note — Section 3 of ch. 305 Laws of 2016, effective from and after July 1, 2016 (approved April 4, 2016), amended this section. Section 29 of ch. 459, Laws of 2016, effective from and after July 1, 2016 (approved May 6, 2016), also amended this section. As set out above, this section reflects the language of both amendments pursuant to Section 1-1-109, which gives the Joint Legislative Committee on Compilation, Revision and Publication of Legislation authority to integrate amendments so that all versions of the same code section enacted within the same legislative session may become effective. The Joint Committee on Compilation, Revision and Publication of Legislation ratified the integration of these amendments as consistent with the legislative intent at the August 5, 2016, meeting of the Committee.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.'"

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

§ 83-17-73. Licensing required before individual may accept commission for selling; employees or authorized agents of limited license rental car company may receive commission under rental car company's limited license.

(1) An insurance company or insurance producer shall not pay a commission, service fee, brokerage or other valuable consideration to a person for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this article and is not so licensed.

(2) A person shall not accept a commission, service fee, brokerage or other valuable consideration for selling, soliciting or negotiating insurance in this state if that person is required to be licensed under this article and is not so licensed.

(3) Renewal or other deferred commissions may be paid to a person for selling, soliciting or negotiating insurance in this state if the person was required to be licensed under this article at the time of the sale, solicitation or negotiation and was so licensed at that time.

(4) An insurer or insurance producer may pay or assign commissions, service fees, brokerages or other valuable consideration to an insurance agency or to persons who do not sell, solicit or negotiate insurance in this state, unless the payment would violate Section 83-17-7 or any other applicable provision of Title 83, Mississippi Code of 1972.

(5) Notwithstanding any provision in this section to the contrary, employees and authorized agents of a limited license rental car company:

(a) May receive compensation for activities under the rental car company's limited license that is incidental to their overall compensation, including, but not limited to, commissions, bonuses and other valuable consideration;

(b) May offer, sell or solicit, in connection with and incidental to the rental of rental cars, the kinds of insurance specified in Section 83-17-63(1)(h) under the limited license of the rental car company; and

(c) Shall not require any additional licensing under this chapter or any other provision of Title 83 relating to paragraph (a) or (b) above.

HISTORY: Laws, 2001, ch. 510, § 12; Laws, 2015, ch. 364, § 4, eff from and after July 1, 2015.

§ 83-17-75. Appointment of producer as agent of insurer.

(1) An insurance producer shall not act as an agent of an insurer unless the insurance producer becomes an appointed agent of that insurer. An insurance producer who is not acting as an agent of an insurer is not required to become appointed.

(2) To appoint a producer as its agent, the appointing insurer shall file, in a format approved by the commissioner, a notice of appointment within fifteen (15) days from the date the agency contract is executed or the first insurance application is submitted. An insurer may also elect to appoint a producer to all or some insurers within the insurer's holding company system or group by the filing of a single appointment request.

(3) Upon receipt of the notice of appointment, the commissioner shall verify within a reasonable time not to exceed thirty (30) days that the insurance producer is eligible for appointment. If the insurance producer is determined to be ineligible for appointment, the commissioner shall notify the insurer within five (5) days of its determination.

(4) An insurer shall pay an appointment fee, in the amount and method of payment set forth in Section 83-5-73 for each insurance producer appointed by the insurer.

(5) An insurer shall remit, in a manner prescribed by the commissioner, a renewal appointment fee in the amount set forth in Section 83-5-73.

(6) Before the issuance of a license or certificate of authority, the commissioner shall require the company requesting appointment of the applicant as producer for the first time to furnish a certificate to the commissioner, verified by an executive officer or managing general or special agent of such company, that the company has duly investigated the character and record of such person and has satisfied itself that such person is of good moral character and is qualified, fit and trustworthy to act as its producer. The Commissioner of Insurance may at any time require any company to obtain a credit report on a producer if the commissioner deems such request advisable. Should such credit report reflect information regarding an offense or violation in relation to which the Department of Insurance has taken action, such information shall not render the applicant ineligible for a license if applicant has complied with the order of the commissioner regarding such offense.

HISTORY: Laws, 2001, ch. 510, § 13; Laws, 2002, ch. 322, § 2; Laws, 2006, ch. 314, § 2, eff from and after July 1, 2006.

JUDICIAL DECISIONS

1. Suspension of license.

When a contractor sued insurers and their agent for negligently issuing a bid bond without authority, due to expiration of the agent's certificate for failure to pay a renewal fee, summary judgment erred because the agent was unauthorized to issue the bond, which had to be valid on the date issued but was null and void, and a later payment of the fee and reinstatement of the agent did not retroactively validate the bond, so fact questions existed as to the negligent issuance of the bond contrary to a duty to the contractor. King Metal Bldgs., Inc. v. Renasant Ins., Inc., 159 So. 3d 567, 2014 Miss. App. LEXIS 377 (Miss. Ct. App. 2014), cert. denied, 158 So. 3d 1153, 2015 Miss. LEXIS 142 (Miss. 2015).

§ 83-17-77. Notification of termination of insurance business relationship; termination procedure; immunity from civil liability absent actual malice; confidential and privileged information.

(1) An insurer or authorized representative of the insurer that terminates the appointment, employment, contract or other insurance business relationship with a producer shall notify the commissioner within thirty (30) days following the effective date of the termination, using a format prescribed by the commissioner, if the reason for termination is one of the reasons set forth in Section 83-17-71 or the insurer has knowledge the producer was found by a court government body or self-regulatory organization authorized by law to have engaged in any of the activities in Section 83-17-71. Upon the written request of the commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination or activity of the producer.

(2) An insurer or authorized representative of the insurer that terminates the appointment, employment or contract with a producer for any reason not set forth in Section 83-17-71 shall notify the commissioner within thirty (30) days following the effective date of the termination using a format prescribed by the commissioner. Upon written request of the commissioner, the insurer shall provide additional information, documents, records or other data pertaining to the termination.

(3) The insurer or the authorized representative of the insurer shall promptly notify the commissioner in a format acceptable to the commissioner if, upon further review or investigation, the insurer discovers additional information that would have been reportable to the commissioner in accordance with subsection (1) of this section had the insurer then known of its existence.

(4)(a) Within fifteen (15) days after making the notification required by subsections (1), (2) and (3) of this section, the insurer shall mail a copy of the notification to the producer at his or her last known address. If the producer is terminated for cause for any of the reasons listed in Section 83-17-71, the insurer shall provide a copy of the notification to the producer at his or her last known address by certified mail, return receipt requested, postage prepaid or by overnight delivery using a nationally recognized carrier.

(b) Within thirty (30) days after the producer has received the original or additional notification, the producer may file written comments concerning the substance of the notification with the commissioner. The producer shall, by the same means, simultaneously send a copy of the comments to the reporting insurer, and the comments shall become a part of the commissioner's file and accompany every copy of a report distributed or disclosed for any reason about the producer as permitted under subsection (6) of this section.

(5)(a) In the absence of actual malice, an insurer, the authorized representative of the insurer, a producer, the commissioner or an organization of which the commissioner is a member and that compiles the information and makes it available to other commissioners or regulatory or law enforcement agencies shall not be subject to civil liability, and a civil cause of action of any nature shall not arise against these entities or their respective agents or employees, as a result of any statement or information required by or provided under this section or any information relating to any statement that may be requested in writing by the commissioner from an insurer or producer or a statement by a terminating insurer or producer to an insurer or producer limited solely and exclusively to whether a termination for cause under subsection (1) of this section was reported to the commissioner if the propriety of any termination for cause under subsection (1) of this section is certified in writing by an officer or authorized representative of the insurer or producer terminating the relationship.

(b) In any action brought against a person that may have immunity under paragraph (a) of this subsection for making any statement required by this section or providing any information relating to any statement that may be requested by the commissioner, the party bringing the action shall plead specifically in any allegation that paragraph (a) of this subsection does not apply because the person making the statement or providing the information did so with actual malice.

(c) Paragraph (a) or (b) of this subsection shall not abrogate or modify any existing statutory or common law privileges or immunities.

(6)(a) Any documents, materials or other information in the control or possession of the Department of Insurance that is furnished by an insurer, producer or an employee or agent thereof acting on behalf of the insurer or producer or obtained by the commissioner in an investigation under this section shall be confidential by law and privileged, shall not be subject to the Public Records Act, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's duties.

(b) Neither the commissioner nor any person who received documents, materials or other information while acting under the authority of the commissioner shall be permitted or required to testify in any private civil action concerning any confidential documents, materials or information subject to paragraph (a) of this subsection.

(c) In order to assist in the performance of the commissioner's duties under this article, the commissioner:

(i) May share documents, materials or other information, including the confidential and privileged documents, materials or information subject to paragraph (a) of this subsection, with other state, federal and international regulatory agencies, with the National Association of Insurance Commissioners, its affiliates or subsidiaries and with state, federal and international law enforcement authorities, if the recipient agrees to maintain the confidentiality and privileged status of the document, material or other information;

(ii) May receive documents, materials or information, including otherwise confidential and privileged documents, materials or information, from the National Association of Insurance Commissioners, its affiliates or subsidiaries and from regulatory and law enforcement officials of other foreign or domestic jurisdictions and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(iii) May enter into agreements governing sharing and use of information consistent with this subsection.

(d) No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the commissioner under this section or as a result of sharing as authorized in paragraph (c) of this subsection.

(e) Nothing in this article shall prohibit the commissioner from releasing final, adjudicated actions including for cause terminations that are open to public inspection pursuant to the Public Records Act to a database or other clearinghouse service maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries of the National Association of Insurance Commissioners.

(7) An insurer, the authorized representative of the insurer or producer that fails to report as required under the provisions of this section or that is found to have reported with actual malice by a court of competent jurisdiction may, after notice and hearing, have its license or certificate of authority suspended or revoked and may be fined in accordance with all applicable statutes.

HISTORY: Laws, 2001, ch. 510, § 14, eff from and after Jan. 1, 2002.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in a statutory reference. The reference in (4)(a) to "Section 11 of this act" was changed to "Section 83-17-71." The Joint Committee ratified the correction at its June 3, 2003 meeting.

Cross References — Mississippi Public Records Act, see § 25-61-1 et seq.

§ 83-17-79. Reciprocity.

(1) The commissioner shall waive any requirements for a nonresident license applicant with a valid license from his or her home state, except the requirements imposed by Section 83-17-65, if the applicant's home state awards nonresident licenses to residents of this state on the same basis.

(2) A nonresident producer's satisfaction of his or her home state's continuing education requirements for licensed insurance producers shall constitute satisfaction of this state's continuing education requirements if the nonresident producer's home state recognizes the satisfaction of its continuing education requirements imposed upon producers from this state on the same basis.

HISTORY: Laws, 2001, ch. 510, § 15, eff from and after Jan. 1, 2002.

§ 83-17-81. Producer to report to commissioner any administrative or criminal action initiated against producer.

(1) A producer shall report to the commissioner any administrative action taken against the producer in another jurisdiction or by another governmental agency in this state within thirty (30) days of the final disposition of the matter. This report shall include a copy of the order, consent to order or other relevant legal documents.

(2) Within thirty (30) days of the initial pretrial hearing date, a producer shall report to the commissioner any criminal prosecution of the producer taken in any jurisdiction. The report shall include a copy of the initial complaint filed, the order resulting from the hearing and any other relevant legal documents.

HISTORY: Laws, 2001, ch. 510, § 16, eff from and after Jan. 1, 2002.

§ 83-17-83. Appellate review.

Any person aggrieved by any action or decision of the Commissioner of Insurance under the provisions of this article may appeal therefrom, within thirty (30) days after receipt of notice thereof, to the Circuit Court of the First Judicial District of Hinds County by certiorari in the manner provided by law. Such appeal shall be without supersedeas, except that the court may grant supersedeas as otherwise provided by law where the license is revoked. The court shall have the authority and jurisdiction to hear the appeal and render its decision in regard thereto in termtime or vacation.

HISTORY: Laws, 2001, ch. 510, § 17; Laws, 2007, ch. 372, § 1, eff from and after July 1, 2007.

§ 83-17-85. Inquisitorial and subpoena power of commissioner.

For the purpose of making such investigations as he may deem necessary for the proper administration of this article, the commissioner shall have inquisitorial powers and shall be empowered to subpoena witnesses and examine them under oath, provided that all testimony, documents, and other evidence required to be submitted to the commissioner pursuant to this article shall be privileged and shall not be admissible as evidence in any other proceeding.

HISTORY: Laws, 2001, ch. 510, § 18, eff from and after Jan. 1, 2002.

§ 83-17-87. Regulations.

The commissioner may, in accordance with Section 25-43-1.101 et seq., promulgate reasonable regulations as are necessary or proper to carry out the purposes of this article.

HISTORY: Laws, 2001, ch. 510, § 19, eff from and after Jan. 1, 2002.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section 25-43-1.101" for "Section 25-43-1" in the middle of this section. The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-17-89. Severability.

If any provisions of this article, or the application of a provision to any person or circumstances, shall be held invalid, the remainder of the article, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

HISTORY: Laws, 2001, ch. 510, § 20, eff from and after Jan. 1, 2002.

ARTICLE 3.

REGULATION OF AGENTS FOR LIFE, HEALTH, OR ACCIDENT INSURERS. [REPEALED]

Sec.
83-17-101 through 83-17-135. Repealed.

§§ 83-17-101 through 83-17-135. Repealed.

Repealed by Laws, 2001, ch. 510, § 34, eff from and after January 1, 2002.

§ 83-17-101. [Codes, 1942, § 5722-01; Laws, 1960, ch. 367, § 1; Laws, 1977, ch. 334, § 1; Laws, 1978, ch. 462, § 1; Laws, 1997, ch. 410, § 10; Laws, 1999, ch. 487, § 7.]

§ 83-17-103. [Codes, 1942, § 5722-02; Laws, 1960, ch. 367, § 2.]

§ 83-17-105. [Codes, 1942, § 5722-03; Laws, 1960, ch. 367, § 3; Laws, 1978, ch. 462, § 2.]

§ 83-17-107. [Codes, 1942, § 5722-04; Laws, 1960, ch. 367, § 4; Laws, 1962, ch. 464; Laws, 1974, ch. 442, § 3; Laws, 1985, ch. 315, § 1; Laws, 1988, ch. 375, § 1; Laws, 1997, ch. 588, § 68.]

§ 83-17-109. [Codes, 1942, § 5722-05; Laws, 1960, ch. 367, § 5.]

§ 83-17-111. [Codes, 1942, § 5722-06; Laws, 1960, ch. 367, § 6.]

§ 83-17-113. [Codes, 1942, § 5722-07; Laws, 1960, ch. 367, § 7; Laws, 1971, ch. 408, § 1; Laws, 1999, ch. 351, § 1.]

§ 83-17-115. [Codes, 1942, § 5722-08; Laws, 1960, ch. 367, § 8.]

§ 83-17-117. [Codes, 1942, § 5722-09; Laws, 1960, ch. 367, § 9; Laws, 1976, ch. 433; Laws, 1995, ch. 361, § 1.]

§ 83-17-119. [Codes, 1942, § 5722-10; Laws, 1960, ch. 367, § 10.]

§ 83-17-121. [Codes, 1942, § 5722-11; Laws, 1960, ch. 367, § 11.]

§ 83-17-123. [Codes, 1942, § 5722-12; Laws, 1960, ch. 367, § 12; Laws, 1997, ch. 410, § 6.]

§ 83-17-125. [Codes, 1942, § 5722-13; Laws, 1960, ch. 367, § 13.]

§ 83-17-127. [Codes, 1942, § 5722-14; Laws, 1960, ch. 367, § 14.]

§ 83-17-129. [Codes, 1942, § 5722-15; Laws, 1960, ch. 367, § 15.]

§ 83-17-131. [Codes, 1942, § 5722-16; Laws, 1960, ch. 367, § 16.]

§ 83-17-133. [Codes, 1942, § 5722-18; Laws, 1960, ch. 367, § 18.]

§ 83-17-135. [Codes, 1942, § 5722-21; Laws, 1960, ch. 367, § 21.]

Editor's Notes — Former § 83-17-101 was entitled "Definitions."

Former § 83-17-103 was entitled "Acting for unauthorized insurer prohibited."

Former § 83-17-105 was entitled "Acting as agent without license prohibited."

Former § 83-17-107 was entitled "Application for license. "

Former § 83-17-109 was entitled "Examination of applicant for license."

Former § 83-17-111 was entitled "Issuance or refusal of license."

Former § 83-17-113 was entitled "Nonresidents may be licensed."

Former § 83-17-115 was entitled "Agent may be licensed to represent additional insurers."

Former § 83-17-117 was entitled "Expiration and renewal of license."

Former § 83-17-119 was entitled "Temporary license."

Former § 83-17-121 was entitled "Termination of agent by insurer."

Former § 83-17-123 was entitled "Refusal, suspension, or revocation of license."

Former § 83-17-125 was entitled "Judicial review of acts of commissioner."

Former § 83-17-127 was entitled "Change of address of agent."

Former § 83-17-129 was entitled "Rules and regulations."

Former § 83-17-131 was entitled "Evidence privileged in investigations by commissioner."

Former § 83-17-133 was entitled "Penalties for violations of this article."

Former § 83-17-135 was entitled "Article inapplicable to certain agents and solicitors."

ARTICLE 5.

REGULATION OF AGENTS FOR FIRE AND OTHER INSURERS. [REPEALED]

Sec.
83-17-201 through 83-17-223. Repealed.
83-17-225 through 83-17-233. Repealed.

§§ 83-17-201 through 83-17-223. Repealed.

Repealed by Laws, 2001, ch. 510, § 34, eff from and after January 1, 2002.

§ 83-17-201. [Codes, 1942, § 5723-01; Laws, 1948, ch. 352, § 1; Laws, 1962, ch. 466 § 1; Laws, 1964, ch. 472, § 1.]

§ 83-17-203. [Codes, 1942, § 5723-01; Laws, 1948, ch. 352, § 1; Laws, 1962, ch. 466 § 1; Laws, 1964, ch. 472, § 1; Laws, 1999, ch. 487, § 8.]

§ 83-17-205. [Codes, 1942, § 5723-02; Laws, 1948, ch. 352, § 2; Laws, 1964, ch. 472, § 2; Laws, 1988, ch. 375 § 2; Laws, 1994, ch. 328, § 1; Laws, 1997, ch. 588, § 69.]

§ 83-17-207. [Codes, 1942, § 5723-02; Laws, 1948, ch. 352, § 2; Laws, 1964, ch. 472, § 2.]

§ 83-17-209. [Codes, 1942, § 5723-02; Laws, 1948, ch. 352. § 2; Laws, 1964, ch. 472, § 2; Laws, 1974, ch. 442, § 4; Laws, 1985, ch. 315, § 2.]

§ 83-17-211. [Codes, 1942, § 5723-02; Laws, 1948, ch. 352, § 2; Laws, 1964, ch. 472, § 2.]

§ 83-17-213. [Codes, 1942, § 5723-02; Laws, 1948, ch. 352, § 2; Laws, 1964, ch. 472, § 2; Laws, 1996, ch. 507, § 85.]

§ 83-17-215. [Codes, 1942, § 5723-02; Laws, 1948, ch. 352, § 2; Laws, 1964, ch. 472, § 2; Laws, 1974, ch. 442, § 5; Laws, 1996, ch. 507, § 86.]

§ 83-17-217. [Codes, 1942, § 5723-03; Laws, 1948, ch. 352, § 3; Laws, 1964, ch. 472, § 3.]

§ 83-17-219. [Codes, 1942, § 5723-04; Laws, 1948, ch. 352, § 4; Laws, 1964, ch. 472, § 4.]

§ 83-17-221. [Codes, 1942, § 5723-04; Laws, 1948, ch. 352, § 4; Laws, 1964, ch. 472, § 4; Laws, 1996, ch. 507, § 87; Laws, 1997, ch. 410, § 7.]

§ 83-17-223. [Codes, 1942, § 5723-05; Laws, 1948, ch. 352, § 5; Laws, 1964, ch. 472, § 5; Laws, 2001, ch. 510, § 34.]

Editor's Notes — Former § 83-17-201 was entitled "Scope of article."

Former § 83-17-203 was entitled "Definitions."

Former § 83-17-205 was entitled "Proof of qualifications of applicant for license."

Former § 83-17-207 was entitled "Powers of commissioner."

Former § 83-17-209 was entitled "Examination of applicant for license."

Former § 83-17-211 was entitled "Rules and regulations."

Former § 83-17-213 was entitled "Temporary license."

Former § 83-17-215 was entitled "Suspension of agent by insurer."

Former § 83-17-217 was entitled "Certificate of appointment of insurance solicitor."

Former § 83-17-219 was entitled "Investigations."

Former § 83-17-221 was entitled "Refusal, suspension, or revocation of license; administrative fines."

Former § 83-17-223 was entitled "Appeals."

§§ 83-17-225 through 83-17-233. Repealed.

Repealed by Laws, 1999, ch. 367, § 1, eff from and after March 15, 1999.

§ 83-17-225. [Codes, 1942, § 5723-06; Laws, 1948, ch. 352, § 6; Laws, 1964, ch. 472, § 6, eff from and after passage (approved June 1, 1964)].

§ 83-17-227. [Laws, 1974, ch. 537, § 1, eff from and after passage (approved April 5, 1974)].

§ 83-17-229. [Laws, 1974, ch. 537, § 2, eff from and after passage (approved April 5, 1974)].

§ 83-17-231. [Laws, 1974, ch. 537, § 3, eff from and after passage (approved April 5, 1974)].

§ 83-17-233. [Laws, 1974, ch. 537, § 4, eff from and after passage (approved April 5, 1974)].

Editor's Notes — Former § 83-17-225 related to the cumulative nature of the article.

Former § 83-17-227 related to prohibition as to licensing of officers or employees of lending institution, public utility or holding company; definitions.

Former § 83-17-229 related to prohibition as to licensing of officers or employees of lending institution, public utility or holding company; exceptions.

Former § 83-17-231 related to prohibition as to licensing of officers or employees of lending institution, public utility or holding company; regulations.

Former § 83-17-233 related to prohibition as to licensing of officers or employees of lending institution, public utility or holding company; application of law.

ARTICLE 6.

PRELICENSING AND CONTINUING EDUCATION FOR INSURANCE AGENTS; REQUIRED FOR LICENSURE.

Sec.

83-17-251. Completion of approved prelicensing and continuing educational courses; exemptions from prelicensing educational requirements; number of classroom hours required; exemptions from continuing educational requirements.
83-17-253. Prelicensing educational and continuing educational program requirements; establishment of standards for evaluating programs.
83-17-255. Prelicensing and continuing educational advisory committee; membership; quorum.
83-17-257. Certification of attendance and completion of prelicensing and continuing educational programs; exceptions.
83-17-259. Commissioner of Insurance may grant exception or extension of time.
83-17-261. Failure of agent to meet educational requirements; penalties.

§ 83-17-251. Completion of approved prelicensing and continuing educational courses; exemptions from prelicensing educational requirements; number of classroom hours required; exemptions from continuing educational requirements.

(1) Every individual seeking to be licensed as an insurance producer in the State of Mississippi, as a condition of issuance of an original license, must furnish the Commissioner of Insurance certification on a form prescribed by

the commissioner that he or she has completed an approved prelicensing course of study for the line of insurance requested.

(2) The prelicensing course of study hours shall consist of twenty (20) hours of approved prelicensing education courses per line of authority. The Commissioner of Insurance shall determine the content requirements for each prelicensing course of study. The prelicensing educational requirements of this section shall not apply to:

(a) An individual that is exempt from taking the written examination as provided in Section 83-17-39(1) and Section 83-17-67.

(b) An individual who has received a bachelor's degree with major coursework in insurance from an accredited institution of higher learning.

(c) An individual holding a current and valid CEBS, CHFC, CIC, CFP, CLU, FLMI, LUTCF designation is exempt for the life line of authority.

(d) An individual holding a current and valid RHU, CEBS, REBC, HIA designation is exempt for the accident and health or sickness line of authority.

(e) An individual holding a current and valid AAI, ARM, CIC, CPCU designation is exempt for the property and casualty lines of authority.

(f) Limited lines insurance producer and limited lines credit insurance producer as defined in Section 83-17-53.

(g) An individual that is seeking licensure for the variable life and variable annuity products line of authority only.

(3) Every individual seeking renewal of an insurance producer license, which has been in effect for a term of eighteen (18) months or less shall satisfactorily complete twelve (12) hours of study in approved continuing education courses. Every individual seeking renewal of an insurance producer license, which has been in effect for a term of more than eighteen (18) months shall satisfactorily complete twenty-four (24) hours of study in approved continuing education courses, of which three (3) hours shall have a course concentration in ethics.

(4) The continuing educational requirements of this section shall not apply to:

(a) Any individual that is exempt from taking the written examination as provided in Section 83-17-39(1) (b), (c), (e) and (g);

(b) Any limited lines producer or limited lines credit insurance producer;

(c) A person not a resident of this state who meets the continuing educational requirement in the state in which such person resides and Mississippi has a reciprocal agreement with that state; or

(d) Nonactive agents as defined in Section 83-17-1.

HISTORY: Laws, 1999, ch. 487, § 1; Laws, 2001, ch. 510, § 32; Laws, 2009, ch. 448, § 9, eff from and after Nov. 1, 2009.

RESEARCH REFERENCES

Practice References.
New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-17-253. Prelicensing educational and continuing educational program requirements; establishment of standards for evaluating programs.

(1) To qualify for credit towards satisfaction of the requirements of this section, an educational program must be a formal program of learning which contributes directly to the professional competence of the licensee and such program must meet the standards outlined herein for prelicensing educational and continuing educational programs. The subject of each course must be approved for the lines of insurance for which the licensee is granted educational credit.

(2) Formal programs requiring attendance or self-study may be considered for credit if the required fees are paid and they meet the standards set forth by the commissioner. Course approval shall be valid for twenty-four (24) months from the date of issuance of approval.

(3) Continuing educational credit shall be allowed for service as an instructor of certified programs at any program for which participants are eligible to receive continuing educational credit. Credit for such service shall be awarded on the first presentation only unless a program has been substantially revised.

(4) Courses for prelicensing and continuing educational credit shall not be advertised or offered unless they have been approved by the commissioner or his designated advisory committee.

(5) The commissioner may grant exceptions to the requirements of this article for extenuating circumstances.

(6) The commissioner specifically reserves the right to approve or disapprove credit for prelicensing education and continuing education claimed under this section.

(7) The Commissioner of Insurance may require any original publisher or provider to submit all material to be used in his or her program to the Department of Insurance or his designee for review.

(8) All providers shall maintain a record of persons attending each course for not less than five (5) years and shall provide certificates of completion with hours earned to students upon their successful completion of each course. The certificate shall bear the course identification number as assigned by the Commissioner of Insurance or his designee.

(9) The Commissioner of Insurance may, in his discretion, designate an independent evaluation educational service to evaluate and administer education programs, subject to his direction and approval. The evaluation fee charged by such educational service shall be paid by the applicant to the service.

HISTORY: Laws, 1999, ch. 487, § 2; Laws, 2009, ch. 448, § 10, eff from and after Nov. 1, 2009.

§ 83-17-255. Prelicensing and continuing educational advisory committee; membership; quorum.

(1) A prelicensing and continuing educational advisory committee, comprised of at least three (3) but not more than seven (7) individuals, may be appointed by and shall serve at the pleasure of the Commissioner of Insurance to advise the commissioner concerning prelicensing and continuing educational standards. Each committee member shall agree to serve a minimum of two (2) years. The chairman of the committee shall be appointed by and shall serve at the pleasure of the commissioner.

(2) A majority of those present at any meeting of the educational advisory committee shall be a quorum for purposes of performing the duties of the committee under this section.

(3) The committee may advise the commissioner on program content and exceptions as permitted under this section.

(4) The committee shall be available to consider other related matters as the commissioner may assign.

HISTORY: Laws, 1999, ch. 487, § 3; Laws, 2009, ch. 448, § 11, eff from and after Nov. 1, 2009.

§ 83-17-257. Certification of attendance and completion of prelicensing and continuing educational programs; exceptions.

(1) Educational providers shall submit proof of each attendee's successful completion of approved prelicensing and continuing educational programs to the Commissioner of Insurance in an electronic format approved by the commissioner within thirty (30) days of the course completion.

(2) The commissioner may grant exceptions to the requirements of this section for reasonable and just causes.

(3) The responsibility for establishing whether a particular course or other program for which credit is claimed is acceptable and meets the continuing educational requirements as set forth in this section rests solely on the licensee.

HISTORY: Laws, 1999, ch. 487, § 4; Laws, 2009, ch. 448, § 12, eff from and after Nov. 1, 2009.

§ 83-17-259. Commissioner of Insurance may grant exception or extension of time.

The Commissioner of Insurance, upon written request, may grant exception to or extend the time in which a licensee must comply with the continuing educational requirements of this section for reasons of poor health, military service or other reasonable and just causes.

HISTORY: Laws, 1999, ch. 487, § 5, eff from and after July 1, 2000.

§ 83-17-261. Failure of agent to meet educational requirements; penalties.

(1) Any individual failing to meet the requirements of this section and who has not been granted an extension of time within which to comply or who has submitted to the Commissioner of Insurance a false or fraudulent certificate of compliance shall be subject to suspension or revocation of all licenses issued for any kind or kinds of insurance. The individual shall be notified of his right to a hearing. No further license shall be issued to such person for any kind or kinds of insurance until such time as the person has demonstrated to the satisfaction of the commissioner that he or she has complied with all requirements of this section and all other laws applicable thereto.

(2) The Commissioner of Insurance may suspend, revoke or refuse to renew a course provider's authority to offer courses for any of the following causes:

(a) Advertising that a course is approved before the commissioner has granted such approval in writing;

(b) Submitting a course outline with material inaccuracies, either in length, presentation time or topic content;

(c) Presenting or using unapproved material in providing an approved course;

(d) Failing to conduct a course for the full time specified in the approval request submitted to the commissioner;

(e) Preparing and distributing certificates of attendance or completion before the course has been approved;

(f) Issuing certificates of attendance or completion before the completion of the course;

(g) Failing to issue certificates of attendance or completion to any licensee who satisfactorily completes a course;

(h) Failing to notify promptly the Commissioner of Insurance of suspected or known improper activities; or

(i) Any violation of state law.

(3) A course provider is responsible for the activities of persons conducting, supervising, instructing, proctoring, monitoring, moderating, facilitating or in any way responsible for the conduct of any of the activities associated with the course.

(4) In addition, the Commissioner of Insurance may require any of the following upon a finding of a violation of this section:

(a) Refunding all course tuition and fees to licensees;

(b) Providing licensees with a suitable course to replace the course that was found in violation; or

(c) Withdrawal or approval of courses sponsored by such a provider for a period determined by the commissioner.

HISTORY: Laws, 1999, ch. 487, § 6, eff from and after July 1, 2000.

ARTICLE 7.

REMEDIES OF AGENTS. [REPEALED]

Sec.

83-17-301 through 83-17-309. Repealed.

§§ 83-17-301 through 83-17-309. Repealed.

Repealed by Laws, 2001, ch. 510, § 34, eff from and after January 1, 2002.
§ 83-17-301. [Codes, 1942, § 5834-21; Laws, 1962, ch. 456, § 1.]
§ 83-17-303. [Codes, 1942, § 5834-22; Laws, 1962, ch. 456, § 2.]
§ 83-17-305. [Codes, 1942, § 5834-23; Laws, 1962, ch. 456, § 3.]
§ 83-17-307. [Codes, 1942, § 5834-24; Laws, 1962, ch. 456, § 4.]
§ 83-17-309. [Codes, 1942, § 5834-25; Laws, 1962, ch. 456, § 5.]

Editor's Notes — Former § 83-17-301 was entitled "Agents may petition for hearing on fire and casualty rating laws."

Former § 83-17-303 was entitled "Agents may petition for hearing on violations or failure to act."

Former § 83-17-305 was entitled "Hearings."

Former § 83-17-307 was entitled "Service of processes and issuance of orders."

Former § 83-17-309 was entitled "Judicial review."

ARTICLE 9.

LICENSING OF INSURANCE ADJUSTERS.

Sec.

83-17-401. Definitions.
83-17-403. Posing as adjuster prohibited; penalty.
83-17-405. Application for license.
83-17-407. Waiver of license requirement for certain adjuster license applicants; prohibition against denial of reciprocity for applicant licensed in another state solely because applicant is not resident of the United States.
83-17-409. Emergency licenses; conditions for issuing; fee.
83-17-411. Reference of claim to unlicensed adjuster prohibited.
83-17-413. Qualifications for license.
83-17-415. Continuing education requirement; certification of programs.
83-17-417. Examination requirement; exceptions; subject matter; manual.
83-17-419. License period; renewal.
83-17-421. Grounds for suspension, revocation or refusal to renew license; notice; hearing; other procedures; period for which revocation precludes new application.
83-17-423. Appeals.
83-17-425. Article supplemental to other statutes.

§ 83-17-401. Definitions.

As used in this article, unless the context otherwise requires:

(a) "Adjuster" means any person who, as an independent contractor, or as an employee of an independent contractor, adjustment bureau, association, insurance company or corporation, managing general agent or self-insured, investigates or adjusts losses on behalf of either an insurer or a self-insured, or any person who supervises the handling of claims. "Adjuster" shall not include:

(i) An attorney-at-law who adjusts insurance losses from time to time and incidental to the practice of law, and who does not advertise or represent that he is an adjuster;

(ii) A salaried employee of an insurer who is regularly engaged in the adjustment, investigation or supervision of insurance claims;

(iii) Persons employed only for the purpose of furnishing technical assistance to a licensed adjuster, including, but not limited to, photographers, estimators, private detectives, engineers, handwriting experts and attorneys-at-law;

(iv) A licensed agent or general agent of an authorized insurer who processes undisputed or uncontested losses, or both, for such insurer under policies issued by the licensed agent or general agent;

(v) A person who performs clerical duties with no negotiations with the parties on disputed or contested claims, or both;

(vi) Any person who handles claims arising under life, accident and health insurance policies;

(vii) Any person who is a multiperil crop insurance adjuster; or

(viii) Any person who collects claim information from, or furnishes claim information to, insureds or claimants, and who performs data entry including entering data into an automated claims adjudication system, if the person is an employee of a licensed independent adjuster or its affiliate where no more than twenty-five (25) such persons are under the supervision of one (1) licensed independent adjuster or licensed agent. A licensed agent who is acting as a supervisor and adjusting portable electronics insurance claims in accordance with this subparagraph does not need to be licensed as an adjuster.

(b) "Insurer" means any insurance company or self-insured.

(c) "Commissioner" means the Commissioner of Insurance.

(d) "Automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation and final resolution of portable electronics insurance claims which:

(i) May only be utilized by a licensed independent adjuster, licensed agent or supervised persons operating in accordance with paragraph (a)(viii) of this section; and

(ii) Must comply with all claims payment requirements of the insurance code; and must be certified as compliant with this section by a licensed independent adjuster that is an officer of a licensed business entity under this chapter.

(e) "Workers' compensation adjuster" means an adjuster whose scope of licensure is limited to workers' compensation insurance. A workers' compensation adjuster may not represent an insured individual. A workers' compensation adjuster must comply with all licensing and continuing education requirements as are prescribed by the commissioner pursuant to this article.

HISTORY: Laws, 1993, ch. 433, § 1; Laws, 2011, ch. 474, § 1; Laws, 2012, ch. 313, § 1; Laws, 2016, ch. 468, § 2, eff from and after July 1, 2016.

OPINIONS OF THE ATTORNEY GENERAL

Public adjusters perform public adjusting services in Mississippi. Dale, Sept. 14, 2005, A.G. Op. 05-0481.

In light of the need for Mississippi policy holders to have access to the services of reputable public adjusters due to the damage caused by Hurricane Katrina, the Department of Insurance is authorized to establish emergency guidelines to provide for the registration of public adjusters during the period in which the state of emergency is in effect. Dale, Sept. 14, 2005, A.G. Op. 05-0481.

RESEARCH REFERENCES

Am. Jur.

44A Am. Jur. 2d, Insurance §§ 1635-1638.

CJS.

46A C.J.S., Insurance §§ 1874-1876.

Practice References.

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-17-403. Posing as adjuster prohibited; penalty.

(1) No person shall act as or hold himself out to be an adjuster in this state unless he is licensed therefor by the Commissioner of Insurance in this state, except that an individual, who is undergoing education and training as an adjuster under the direction and supervision of a licensed adjuster for a period not exceeding twelve (12) months may act as an adjuster without having an adjuster's license, if at the beginning of such training period, the name of such trainee has been registered as such with the commissioner.

(2) Any person who violates the provisions of this section shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than Two Hundred Fifty Dollars ($250.00) or by confinement in the county jail for not more than six (6) months, or by both such fine and confinement.

HISTORY: Laws, 1993, ch. 433, § 2, eff from and after July 1, 1993.

§ 83-17-405. Application for license.

Application for a license as an insurance adjuster shall be made to the commissioner upon forms as prescribed and furnished by the commissioner. As a part of, or in connection with, any such application, the applicant shall furnish such information concerning his identity, personal history, experience, business record and any other pertinent facts as the commissioner may reasonably require.

HISTORY: Laws, 1993, ch. 433, § 3, eff from and after July 1, 1993.

§ 83-17-407. Waiver of license requirement for certain adjuster license applicants; prohibition against denial of reciprocity for applicant licensed in another state solely because applicant is not resident of the United States.

The commissioner may waive any license requirement for an applicant with a valid license from another state having license requirements substantially equivalent to those of this state, or an applicant with a certification from a person or entity approved by the commissioner that provides adjuster education and training and has met the standards as set forth by the commissioner regarding pre-licensing coursework and examination. No applicant with a valid license from another state shall be rejected solely on the basis that the individual is not a resident of the United States of America.

HISTORY: Laws, 1993, ch. 433, § 4; Laws, 2012, ch. 313, § 2; Laws, 2017, ch. 317, § 1, eff from and after July 1, 2017.

§ 83-17-409. Emergency licenses; conditions for issuing; fee.

In the event of a catastrophe or emergency which arises out of a disaster, act of God, riot, civil commotion, conflagration or other similar occurrence, the commissioner, upon application, shall issue an emergency license to persons who are residents or nonresidents of this state and who may or may not be otherwise licensed adjusters. Such emergency license shall remain in force for a period not to exceed ninety (90) days, unless extended for an additional period of ninety (90) days by the commissioner. The applicant must be certified by (a) a person licensed under the provisions of this article, or by (b) an insurer who maintains an office in this state and is licensed to do business in this state. The licensed adjuster or insurer who certifies the applicant under the provisions of this section shall be responsible for the loss or claims practices of the emergency license holder.

Within five (5) days of any applicant beginning work as an adjuster under this section, the employer of such adjuster shall certify to the commissioner such application without being deemed in violation of this article, provided that the commissioner, after notice and hearing, may revoke the emergency license upon the grounds as otherwise contained in this article providing for revocation of an adjuster's license.

The fee for an emergency license shall be in an amount not to exceed Fifty Dollars ($50.00) as determined by the commissioner and shall be due and payable within thirty (30) days of the issuance of such emergency license.

HISTORY: Laws, 1993, ch. 433, § 5, eff from and after July 1, 1993.

§ 83-17-411. Reference of claim to unlicensed adjuster prohibited.

An insurer shall not knowingly refer any claim or loss for adjustment in this state to any person purporting to be or acting as an insurance adjuster unless such person is currently licensed as such as required in this article.

HISTORY: Laws, 1993, ch. 433, § 6, eff from and after July 1, 1993.

§ 83-17-413. Qualifications for license.

The commissioner shall license as an insurance adjuster only an individual who has otherwise complied with this article and who has furnished evidence satisfactory to the commissioner that:

(a) He is at least eighteen (18) years of age;

(b) He is a bona fide resident of this state, or is a resident of a state or country which will permit residents of this state to act as insurance adjusters in such other state or country;

(c) If he is a nonresident of the United States, he has complied with all federal laws pertaining to employment or the transaction of business in the United States;

(d) He is a trustworthy person;

(e) He has had experience or special education or training with reference to the handling of loss claims under insurance contracts of sufficient duration and extent to make him competent to fulfill the responsibilities of an insurance adjuster; and

(f) He has successfully passed an examination as required by the commissioner in accordance with this article or has been exempted according to the provisions of this article.

HISTORY: Laws, 1993, ch. 433, § 7, eff from and after July 1, 1993.

§ 83-17-415. Continuing education requirement; certification of programs.

The commissioner shall adopt a procedure for certifying continuing education programs. Each individual seeking renewal of an adjuster license, which has been in effect for a term of eighteen (18) months or less shall satisfactorily complete twelve (12) hours of study in approved continuing education courses. Every individual seeking renewal of an adjuster license, which has been in effect for a term of more than eighteen (18) months shall satisfactorily complete twenty-four (24) hours of study in approved continuing education courses, of which three (3) hours shall have a course concentration in ethics.

HISTORY: Laws, 1993, ch. 433, § 8; Laws, 2016, ch. 468, § 3, eff from and after July 1, 2016.

§ 83-17-417. Examination requirement; exceptions; subject matter; manual.

(1) Each applicant for a license as an adjuster, before the issuance of such license, shall personally take and pass, to the satisfaction of the commissioner, an examination as a test of his qualifications and competency; but the requirement of an examination shall not apply to any of the following:

(a) An applicant who for the one-year period next preceding July 1, 1993, has been principally engaged in the investigation, adjustment or supervision of losses and who is so engaged on July 1, 1993;

(b) An applicant for the renewal of a license issued hereunder;

(c) An applicant who is licensed as an insurance adjuster, as defined by this article, in another state with which state a reciprocal agreement has been entered into by the commissioner;

(d) Any person who possesses a certification from a person or entity approved by the commissioner that provides adjuster education and training and that requires, as a prerequisite to certification, an examination substantially equivalent to those of this state and approved by the commissioner; or

(e) Any person who has completed a course or training program in adjusting of losses as prescribed and approved by the commissioner and is certified to the commissioner upon completion of the course that such person has completed the course or training program, and has passed an examination testing his knowledge and qualification, as prescribed by the commissioner.

(2) Each examination for a license as an adjuster shall be as the commissioner may prescribe and shall be of sufficient scope reasonably to test the applicant's knowledge relative to the kinds of insurance which may be dealt with under the license applied for and the duties, responsibilities and laws of this state applicable to such a licensee.

(3) The commissioner shall prepare and make available to applicants a manual or instructions specifying in general terms the subjects which may be covered in any examination for such a license.

HISTORY: Laws, 1993, ch. 433, § 9; Laws, 2017, ch. 317, § 2, eff from and after July 1, 2017.

§ 83-17-419. License period; renewal.

(1) The privilege license of an individual to act as an adjuster shall continue from the date of issuance for original licenses or from the expiration date for existing licenses until the last day of the month of the licensee's birthday in the second year following issuance or renewal of the license, with a minimum term of thirteen (13) months. The privilege license of a business entity to act as an adjuster shall continue from the date of issuance until May 31, in the second year following issuance or renewal of the license, with a minimum term of thirteen (13) months.

(2) Each adjuster shall file an application for renewal of license on the form and in the manner prescribed by the commissioner for such purpose.

Upon the filing of such application for renewal of license and the payment of the required fees, the current license shall continue to be in force until the renewal license is issued by the commissioner or until the commissioner has refused for cause to issue such renewal license, as provided in this article, and has given notice of such refusal in writing to the adjuster.

HISTORY: Laws, 1993, ch. 433, § 10; Laws, 1996, ch. 305, § 1; Laws, 2016, ch. 468, § 4, eff from and after July 1, 2016.

§ 83-17-421. Grounds for suspension, revocation or refusal to renew license; notice; hearing; other procedures; period for which revocation precludes new application.

(1) A license may be refused, or a license duly issued may be suspended or revoked or the renewal thereof refused by the commissioner if, after notice and hearing as hereinafter provided, he finds that the applicant for, or holder of, such license:

(a) Has wilfully violated any provision of the insurance laws of this state; or

(b) Has intentionally made a material misstatement in the application for such license; or

(c) Has obtained, or attempted to obtain, such license by fraud or misrepresentation; or

(d) Has misappropriated or converted to his own use or illegally withheld money belonging to an insurer or beneficiary; or

(e) Has otherwise demonstrated lack of trustworthiness or competence to act as an adjuster; or

(f) Has been guilty of fraudulent or dishonest practices or has been convicted of a felony; or

(g) Has materially misrepresented the terms and conditions of insurance policies or contracts; or wilfully exaggerated prospective returns on investment features of policies or fails to identify himself as an adjuster and in so doing receives a compensation for his participation in the sale of insurance; or

(h) Has made or issued, or caused to be made or issued, any statement misrepresenting or making incomplete comparisons regarding the terms or conditions of any insurance or annuity contract legally issued by any insurer, for the purpose of inducing or attempting to induce the owner of such contract to forfeit or surrender such contract or allow it to lapse for the purpose of replacing such contract with another; or

(i) Has obtained or attempted to obtain such license, not for the purpose of holding himself out to the general public as an adjuster, but primarily for the purpose of soliciting, negotiating or procuring insurance or annuity contracts covering himself or members of his family.

(2) Before any license shall be refused (except for failure to pass a required written examination) or suspended or revoked or the renewal thereof refused hereunder, the commissioner shall give notice of his intention so to do,

by registered mail, to the applicant for or holder of such license and the insurer whom he represents or who desires that he be licensed, and shall set a date not less than twenty (20) days from the date of mailing such notice when the applicant or licensee and a duly authorized representative of the insurer may appear to be heard and produce evidence. Such notice shall constitute automatic suspension of license if the person involved is a licensed adjuster. In the conduct of such hearing, the commissioner or any regular salaried employee specially designated by him for such purpose shall have power to administer oaths, to require the appearance of and examine any person under oath and to require the production of books, records or papers relevant to the inquiry upon his own initiative or upon the request of the applicant or licensee. Upon the termination of such hearing, findings shall be reduced to writing and, upon approval by the commissioner, shall be filed in his office; and notice of the findings shall be sent by registered mail to the applicant or licensee and the insurer concerned.

(3) Where the grounds set out in subsection (1)(d) or (1)(g) are the grounds for any hearing, the commissioner may, in his discretion in lieu of the hearing provided for in subsection (2) of this section, file a petition to suspend or revoke any license authorized hereunder in a court of competent jurisdiction of the county or district in which the alleged offense occurred. In such cases, subpoenas may be issued for witnesses, and mileage and witness fees paid as in other cases. All costs of such cause shall be paid by the defendant, if found guilty, and if costs cannot be made and collected from the defendant, such costs shall be assessed against the company issuing the contract involved in such cause.

(4) No licensee whose license has been revoked hereunder shall be entitled to file another application for a license as an adjuster within one (1) year from the effective date of such revocation or, if judicial review of such revocation is sought, within one (1) year from the date of final court order or decree affirming such revocation. Such application, when filed, may be refused by the commissioner unless the applicant shows good cause why the revocation of his license shall not be deemed a bar to the issuance of a new license.

HISTORY: Laws, 1993, ch. 433, § 11, eff from and after July 1, 1993.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted “subsection (1)(d) or (1)(g)” for “paragraph (1)(d) or (1)(g)” in the first sentence of (3). The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-17-423. Appeals.

Any person aggrieved by any action or decision of the Commissioner of Insurance under the provisions of this article may appeal therefrom to the Circuit Court of the First Judicial District of Hinds County in the manner provided by law. The circuit court shall have the authority and jurisdiction to hear the appeal and render its decision in regard thereto in termtime or vacation.

HISTORY: Laws, 1993, ch. 433, § 12, eff from and after July 1, 1993.

§ 83-17-425. Article supplemental to other statutes.

This article is declared to be cumulative and supplemental to all other valid statutes relating to insurance agents, solicitors and adjusters.

HISTORY: Laws, 1993, ch. 433, § 13, eff from and after July 1, 1993.

ARTICLE 11.

LICENSING OF PUBLIC ADJUSTERS.

Sec.

83-17-501. Definitions.
83-17-503. Posing as public adjuster prohibited; penalties.
83-17-505. Application for license.
83-17-507. Waiver of license requirement for public adjuster licensed in another state.
83-17-509. Emergency licenses; conditions for issuing; fee.
83-17-511. Qualifications for license.
83-17-513. Continuing education requirement; certification of programs.
83-17-515. Examination requirement; exceptions; subject matter; manual.
83-17-517. Expiration of license; renewal.
83-17-519. Grounds for suspension or revocation of license or refusal to renew; notice; hearing; filing new application after revocation of license; funding of agency expenses; deposit of monies into State General Fund.
83-17-521. Appeals.
83-17-523. Written contract required; compensation; cancellation of contract; ethical requirements.
83-17-525. Article does not entitle person not licensed by Supreme Court to practice law in state.
83-17-527. Article cumulative and supplemental to other statutes; rules and regulations.

§ 83-17-501. Definitions.

As used in this article, unless the context otherwise requires:

(a) "Certified" means, except as used in Section 83-17-519(2), written representations addressed to the commissioner concerning the integrity, competence and qualifications of a person, in form and content satisfactory to the commissioner, or concerning other matters as the commissioner may by regulation hereafter prescribe.

(b) "Commissioner" means the Commissioner of Insurance.

(c) "Department" means the Mississippi Insurance Department.

(d) "Insurer" means any insurance company or self-insured person or entity.

(e) "Public adjuster" means any person who, for compensation or any other thing of value on behalf of the insured and subject to the prohibition provided in Section 73-3-55:

(i) Acts or aids, solely in relation to first party claims arising under insurance contracts that insure the real or personal property of the insured, on behalf of an insured in negotiating for, or effecting the settlement of, a claim for loss or damage covered by an insurance contract;

(ii) Advertises for employment as a public adjuster of insurance claims or solicits business or represents himself or herself to the public as a public adjuster of first party insurance claims for losses or damages arising out of policies of insurance that insure real or personal property; or

(iii) Directly or indirectly solicits business, investigates or adjusts losses, or advises an insured about first party claims for losses or damages arising out of policies of insurance that insure real or personal property for another person engaged in the business of adjusting losses or damages covered by an insurance policy, for the insured.

A public adjuster shall not include an attorney at law who does not advertise or represent that he is a public adjuster.

HISTORY: Laws, 2007, ch. 497, § 1, eff from and after July 1, 2007.

Cross References — Commissioner of insurance generally, see § 83-1-3.
Licensing of insurance adjusters, see §§ 83-17-401 et seq.

RESEARCH REFERENCES

Law Reviews.

Hurricane Katrina Special Edition: Disaster Mediations in Mississippi: The Influx of Public Adjusters into Mississippi after Hurricane Katrina Compels the Mississippi Legislature to Enact the Mississippi Public Adjuster Act, 77 Miss. L.J. 761, Spring, 2008.

Practice References.

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-17-503. Posing as public adjuster prohibited; penalties.

(1) No person shall act as or hold himself out to be a public adjuster in this state unless he is licensed therefor by the commissioner, except that an individual, who is undergoing education and training as a public adjuster under the direction and supervision of a licensed public adjuster for a period not exceeding twelve (12) months may act as a public adjuster without having a public adjuster's license, if at the beginning of such training period, the name of such trainee has been registered as such with the commissioner.

(2) Any person who violates the provisions of this section shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than One Thousand Dollars ($1,000.00) or by confinement in the county jail for not more than one (1) year, or by both such fine and confinement.

HISTORY: Laws, 2007, ch. 497, § 2, eff from and after July 1, 2007.

Cross References — Commissioner of insurance generally, see § 83-1-3.
Posing as an insurance adjuster prohibited, see § 83-17-403.
Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

§ 83-17-505. Application for license.

Application for a license as a public adjuster shall be made to the commissioner upon forms as prescribed and furnished by the commissioner. As a part of, or in connection with, any such application, the applicant shall furnish such information concerning his identity, personal history, experience, business record and any other pertinent facts as the commissioner may reasonably require.

HISTORY: Laws, 2007, ch. 497, § 3, eff from and after July 1, 2007.

Cross References — Commissioner of insurance generally, see § 83-1-3.
Application for insurance adjuster license, see § 83-17-405.

§ 83-17-507. Waiver of license requirement for public adjuster licensed in another state.

The commissioner may waive any license requirement for an applicant with a valid license from another state having license requirements substantially equivalent to those of this state.

HISTORY: Laws, 2007, ch. 497, § 4, eff from and after July 1, 2007.

Cross References — Commissioner of insurance generally, see § 83-1-3.
Waiver of license requirement for insurance adjuster licensed in another state, see § 83-17-407.

§ 83-17-509. Emergency licenses; conditions for issuing; fee.

In the event of a catastrophe or emergency which arises out of a disaster, Act of God, riot, civil commotion, conflagration or other similar occurrence, the commissioner, upon application, may issue an emergency license to persons who are residents or nonresidents of this state and who may or may not be otherwise licensed public adjusters. Such emergency license shall remain in force for a period not to exceed ninety (90) days, unless extended for an additional period of ninety (90) days by the commissioner. The applicant must be certified by (a) a person licensed under the provisions of this article, or by (b) such other person as may be approved by the commissioner. The licensed public adjuster or other person who certifies the applicant under the provisions of this section shall be responsible for the loss or claims practices of the emergency license holder.

Within five (5) days of any applicant beginning work as a public adjuster under this section, the application and certification provided for in the preceding paragraph shall be provided to the commissioner without such public adjuster being deemed in violation of this article, provided that the commissioner, after notice and hearing, may revoke the emergency license upon the grounds as otherwise contained in this article providing for revocation of a public adjuster's license.

The fee for an emergency license shall be in an amount not to exceed Fifty

Dollars ($50.00) as determined by the commissioner and shall be due and payable within thirty (30) days of the issuance of such emergency license.

HISTORY: Laws, 2007, ch. 497, § 5, eff from and after July 1, 2007.

Cross References — Commissioner of insurance generally, see § 83-1-3.
Emergency insurance adjuster license, see § 83-17-409.

§ 83-17-511. Qualifications for license.

The commissioner shall license as a public adjuster only an individual who has otherwise complied with this article and who has furnished evidence satisfactory to the commissioner that:

(a) He is at least twenty-one (21) years of age;

(b) He is a bona fide resident of this state, or is a resident of a state which will permit residents of this state to act as public adjusters in such other state;

(c) He is a trustworthy person;

(d) He has had experience or special education or training with reference to the handling of loss claims under insurance contracts of sufficient duration and extent to make him competent to fulfill the responsibilities of a public adjuster; and

(e) He has successfully passed an examination as required by the commissioner in accordance with this article or has been exempted according to the provisions of this article.

HISTORY: Laws, 2007, ch. 497, § 6, eff from and after July 1, 2007.

Cross References — Commissioner of insurance generally, see § 83-1-3.
Qualifications for insurance adjuster license, see § 83-17-413.

§ 83-17-513. Continuing education requirement; certification of programs.

The commissioner shall adopt a procedure for certifying continuing education programs for public adjusters. Every individual seeking renewal of a public adjuster license, which has been in effect for a term of eighteen (18) months or less shall satisfactorily complete twelve (12) hours of study in approved continuing education courses. Every individual seeking renewal of a public adjuster license, which has been in effect for a term of more than eighteen (18) months shall satisfactorily complete twenty-four (24) hours of study in approved continuing education courses of which three (3) hours shall have a course concentration in ethics.

HISTORY: Laws, 2007, ch. 497, § 7; Laws, 2016, ch. 468, § 5, eff from and after July 1, 2016.

Cross References — Commissioner of insurance generally, see § 83-1-3.
Continuing education requirement for insurance adjusters, see § 83-17-415.

§ 83-17-515. Examination requirement; exceptions; subject matter; manual.

(1) Each applicant for a license as a public adjuster, before the issuance of such license, shall personally take and pass, to the satisfaction of the commissioner, an examination as a test of his qualifications and competency; but the requirement of an examination shall not apply to any of the following:

(a) An applicant for the renewal of a license issued hereunder;

(b) An applicant who is licensed as a public adjuster, as defined by this article, in another state with which state a reciprocal agreement has been entered into by the commissioner; or

(c) Any person who has completed a course or training program in adjusting for losses as prescribed and approved by the commissioner and is certified to the commissioner upon completion of the course that such person has completed the course or training program, and has passed an examination testing his knowledge and qualification, as prescribed by the commissioner.

(2) Each examination for a license as a public adjuster shall be as the commissioner may prescribe and shall be of sufficient scope reasonably to test the applicant's knowledge relative to the kinds of insurance which may be dealt with under the license applied for and the duties, responsibilities and laws of this state applicable to such a licensee.

(3) The commissioner shall prepare and make available to applicants a manual or instructions specifying in general terms the subjects which may be covered in any examination for such a license.

HISTORY: Laws, 2007, ch. 497, § 8, eff from and after July 1, 2007.

Cross References — Commissioner of insurance generally, see § 83-1-3.
Insurance adjuster examination requirement, see § 83-17-417.

§ 83-17-517. Expiration of license; renewal.

(1) The privilege license of an individual to act as a public adjuster shall continue from the date of issuance for original licenses or from the expiration date for existing licenses until the last day of the month of the licensee's birthday in the second year following issuance or renewal of the license, with a minimum term of thirteen (13) months. The privilege license of a business entity to act as a public adjuster shall continue from the date of issuance until May 31 in the second year following issuance or renewal of the license, with a minimum term of thirteen (13) months.

(2) Each public adjuster shall file an application for renewal of license on the form and in the manner prescribed by the commissioner for such purpose. Upon the filing of such application for renewal of license and the payment of the required fees, prior to the expiration date, the current license shall

continue to be in force until the renewal license is issued by the commissioner or until the commissioner has refused for cause to issue such renewal license, as provided in this article, and has given notice of such refusal in writing to the public adjuster.

HISTORY: Laws, 2007, ch. 497, § 9; Laws, 2016, ch. 468, § 6, eff from and after July 1, 2016.

Cross References — Commissioner of insurance generally, see § 83-1-3.
Expiration and renewal of insurance adjuster license, see § 83-17-419.

§ 83-17-519. Grounds for suspension or revocation of license or refusal to renew; notice; hearing; filing new application after revocation of license; funding of agency expenses; deposit of monies into State General Fund.

(1) A license may be refused, or a license duly issued may be suspended or revoked or the renewal thereof refused by the commissioner, or the commissioner may levy a civil penalty in an amount not to exceed Five Thousand Dollars ($5,000.00) per violation, or both, and any such penalty shall be deposited into the special fund of the State Treasury designated as the "Insurance Department Fund," if, after notice and hearing as hereinafter provided, he finds that the applicant for, or holder of, such license:

(a) Has intentionally made a material misstatement in the application for such license; or

(b) Has obtained, or attempted to obtain, such license by fraud or misrepresentation; or

(c) Has misappropriated or converted to his own use or illegally withheld money belonging to another person or entity; or

(d) Has otherwise demonstrated lack of trustworthiness or competence to act as a public adjuster; or

(e) Has been guilty of fraudulent or dishonest practices or has been convicted of a felony; or

(f) Has materially misrepresented the terms and conditions of insurance policies or contracts or failed to identify himself as a public adjuster; or

(g) Has obtained or attempted to obtain such license for a purpose other than holding himself out to the general public as a public adjuster; or

(h) Has violated any insurance laws, or any regulation, subpoena or order of the commissioner or of another state's commissioner of insurance.

(2) Before any license shall be refused (except for failure to pass a required written examination) or suspended or revoked or the renewal thereof refused hereunder, the commissioner shall give notice of his intention so to do, by certified mail, return receipt requested, to the applicant for or holder of such license, and shall set a date not less than twenty (20) days from the date of mailing such notice when the applicant or licensee may appear to be heard and produce evidence in opposition to such refusal, suspension or revocation. Such notice shall constitute automatic suspension of license if the person involved is

a licensed public adjuster. In the conduct of such hearing, the commissioner or any regular salaried employee of the department specially designated by him for such purpose shall have the power to administer oaths, to require the appearance of and examine any person under oath, and to require the production of books, records or papers relevant to the inquiry upon his own initiative or upon the request of the applicant or licensee. Upon the termination of such hearing, findings shall be reduced to writing and, upon approval by the commissioner, shall be filed in his office; and notice of the findings shall be sent by certified mail, return receipt requested, to the applicant or licensee.

(3) Where the grounds set out in subsection (1)(c) or (1)(f) of this section are the grounds for any hearing, the commissioner may, in his discretion in lieu of the hearing provided for in subsection (2) of this section, file a petition requesting the court to suspend or revoke any license authorized hereunder in a court of competent jurisdiction of the county or district in which the alleged offense occurred. In such cases, subpoenas may be issued for witnesses, and mileage and witness fees paid as in other cases. All costs of such cause shall be paid by the defendant, if the finding of the court be against him.

(4) No licensee whose license has been revoked hereunder shall be entitled to file another application for a license as a public adjuster within one (1) year from the effective date of such revocation or, if judicial review of such revocation is sought, within one (1) year from the date of final court order or decree affirming such revocation. An application filed after such one-year period shall be refused by the commissioner unless the applicant shows good cause why the revocation of his license shall not be deemed a bar to the issuance of a new license.

(5) From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

(6) From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Laws, 2007, ch. 497, § 10; Laws, 2016, ch. 459, § 30, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Commissioner of insurance generally, see § 83-1-3.

Grounds for suspension or revocation of insurance adjuster license, see § 83-17-421.

§ 83-17-521. Appeals.

Any person aggrieved by any action or decision of the commissioner under the provisions of this article may appeal therefrom to the Circuit Court of the

First Judicial District of Hinds County in the manner provided by law. The circuit court shall have the authority and jurisdiction to hear the appeal and render its decision in regard thereto in termtime or vacation.

HISTORY: Laws, 2007, ch. 497, § 11, eff from and after July 1, 2007.

Cross References — Commissioner of insurance generally, see § 83-1-3.
Insurance adjuster appeals, see § 83-17-423.

§ 83-17-523. Written contract required; compensation; cancellation of contract; ethical requirements.

(1) Public adjusters shall ensure that all contracts for their services are in writing, signed by the insured and the public adjuster who solicited the contract, and a copy of the contract shall be provided to the insured upon execution. All such contracts shall be subject to the following provisions:

(a) No public adjuster shall charge, agree to, or accept as compensation any payment, commission, fee or other thing of value equal to more than ten percent (10%) of any insurance settlement or the proceeds of any claim investigated.

(b) No public adjuster shall require, demand or accept any fee, retainer, compensation, deposit or other thing of value, prior to partial or full settlement of a claim.

(c) Any costs to be reimbursed to a public adjuster out of the proceeds of a settlement shall be specified by kind and estimated amounts.

(d) A public adjuster's contract with the insured shall be revocable or cancelable by the insured without cause and without penalty or obligation for at least five (5) business days after the contract is executed by the insured. Nothing in this provision shall be construed to prevent an insured from pursuing any civil legal remedy to revoke or cancel the contract after the expiration of such cancellation period.

(2) Public adjusters shall adhere to the following ethical requirements:

(a) No public adjuster shall undertake the adjustment of any claim for which the public adjuster is not currently competent and knowledgeable as to the terms and conditions of the insurance coverage, or which otherwise exceeds the public adjuster's current expertise.

(b) No public adjuster shall, as a public adjuster, represent any person or entity whose claim the public adjuster has previously adjusted while acting as an independent adjuster representing any insurer, either directly or through an independent adjusting firm retained by the insurer.

(c) A public adjuster shall not knowingly make any oral or written material misrepresentations or statements to any insured or potential insured which are false and intended to injure any person engaged in the business of insurance.

(d) No public adjuster shall knowingly enter into a contract to adjust a residential property claim subsequent to a declaration of total loss by an insurer, unless the services to be provided by the public adjuster can reasonably be expected to result in the insured obtaining an insurance settlement, net of the public adjuster's compensation, in excess of the amount the insured would have obtained without the services of the public adjuster.

(e) A public adjuster shall advise each insured that the insured has the right to retain an attorney at law of his choice throughout the public adjuster's investigation and adjustment of the claim.

(f) If the claim is not settled by the public adjuster, the public adjuster shall advise the insured that the insured has the right to retain an attorney at law of his choice.

(g) No public adjuster shall contract for, agree to, or receive anything of value from any attorney at law or other person acting in concert with any attorney at law (i) for referring claims to the attorney, or (ii) in connection with any claim for which the public adjuster has performed or intends to perform services.

(h) No public adjuster shall split any attorney's fee with any attorney at law.

(i) A public adjuster shall not testify as an expert witness in any judicial or administrative proceeding while maintaining a pecuniary interest in the outcome of the proceeding, as otherwise permitted by Section 83-17-523(1)(a); provided, however, that a public adjuster may testify as an expert witness if pursuant to the terms of his contract his compensation is converted to a specified hourly rate, which rate (i) is subject to such limitations as may be prescribed by the commissioner, and (ii) is not subject to any contingencies. In the event of a conversion of the public adjuster's contract to an hourly rate agreement, the prior fee arrangement shall be inadmissible at trial.

HISTORY: Laws, 2007, ch. 497, § 12, eff from and after July 1, 2007.

Cross References — Commissioner of insurance generally, see § 83-1-3.

§ 83-17-525. Article does not entitle person not licensed by Supreme Court to practice law in state.

This article shall not be construed as entitling a person who is not licensed by the Mississippi Supreme Court to practice law in this state.

HISTORY: Laws, 2007, ch. 497, § 13, eff from and after July 1, 2007.

§ 83-17-527. Article cumulative and supplemental to other statutes; rules and regulations.

This article is declared to be cumulative and supplemental to all other valid statutes relating to insurance agents, solicitors, adjusters and public adjusters. The Commissioner of Insurance is directed and authorized to make such reasonable rules and regulations as may be necessary for the administration of this article, including, but not limited to, rules and regulations (a) establishing procedures for the filing and approval of contracts to be used by public adjusters and/or prescribing one or more model contracts for use by public adjusters, (b) regulating solicitations by public adjusters, and (c) establishing bonding and/or errors and omissions insurance requirements for public adjusters.

HISTORY: Laws, 2007, ch. 497, § 14, eff from and after July 1, 2007.

Cross References — Commissioner of insurance generally, see § 83-1-3.

CHAPTER 18.

INSURANCE ADMINISTRATORS AND MANAGING GENERAL AGENTS

Insurance Administrators. 83-18-1
Managing General Agents Act. 83-18-101

INSURANCE ADMINISTRATORS

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§ 83-18-1. Definitions.

As used in this chapter unless the context otherwise requires:

(a) "Administrator" or "third-party administrator" or "TPA" means a person who directly or indirectly solicits or effects coverage of, underwrites, collects charges or premiums from, or adjusts or settles claims on residents of this state, or residents of another state from offices in this state, in connection with life or health insurance coverage or annuities, except any of the following:

(i) An employer on behalf of its employees or the employees of one or more subsidiaries or affiliated corporations of such employer;

(ii) A union on behalf of its members;

(iii) An insurer which is authorized to transact insurance in this state with respect to a policy lawfully issued and delivered in and pursuant to the laws of this state or another state;

(iv) An agent or broker licensed to sell life or health insurance in this state, whose activities are limited exclusively to the sale of insurance;

(v) A creditor on behalf of its debtors with respect to insurance covering a debt between the creditor and its debtors;

(vi) A trust and its trustees, agents and employees acting pursuant to such trust established in conformity with 29 U.S.C. Section 186;

(vii) A trust exempt from taxation under Section 501(a) of the Internal Revenue Code, its trustees and employees acting pursuant to such trust, or a custodian and the custodian's agents or employees acting pursuant to a custodian account which meets the requirements of Section 401(f) of the Internal Revenue Code;

(viii) A credit union or a financial institution which is subject to supervision or examination by federal or state banking authorities, or a mortgage lender, to the extent they collect and remit premiums to licensed insurance agents or authorized insurers in connection with loan payments;

(ix) A credit card issuing company which advances for and collects premiums or charges from its credit card holders who have authorized collection if the company does not adjust or settle claims;

(x) A person who adjusts or settles claims in the normal course of that person's practice or employment as an attorney at law and who does not collect charges or premiums in connection with life or health insurance coverage or annuities;

(xi) An adjuster licensed by this state whose activities are limited to adjustment of claims;

(xii) A person who acts solely as an administrator of one or more bona fide employee benefit plans established by an employer or an employee organization; or

(xiii) A person licensed as a managing general agent in this state, whose activities are limited exclusively to the scope of activities conveyed under such license.

(b) "Affiliate" or "affiliated" means any entity or person who directly or indirectly, through one or more intermediaries, controls or is controlled by, or is under common control with, a specified entity or person.

(c) "Commissioner" means the Commissioner of Insurance.

(d) "Insurance" or "insurance coverage" means any coverage offered or provided by an insurer.

(e) "Insurer" means any person undertaking to provide life or health insurance coverage in this state. For the purposes of this chapter, insurer includes a licensed insurance company, a prepaid hospital or medical care plan, a health maintenance organization, a multiple employer welfare arrangement, or any other person providing a plan of insurance subject to state insurance regulation. Insurer does not include a bona fide employee benefit plan established by an employer or an employee organization, or both, for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974.

(f) "Underwrites" or "underwriting" means, but is not limited to, the acceptance of employer or individual applications for coverage of individuals in accordance with the written rules of the insurer; the overall planning and coordinating of an insurance program; and the ability to procure bonds and excess insurance.

HISTORY: Laws, 1991, ch. 422, § 1, eff from and after July 1, 1991.

Federal Aspects — Sections 401 and 501 of the Internal Revenue Code, see 26 USCS §§ 401, 501. Employee Retirement Income Security Act of 1974, see generally 29 USCS § 1001 et seq.

RESEARCH REFERENCES

ALR.

Duty of liability insurer to initiate settlement negotiations. 51 A.L.R.5th 701.

Requirement that multicoverage umbrella insurance policy offer uninsured-or underinsured-motorist coverage equal to liability limits under umbrella provisions. 52 A.L.R.5th 451.

Practice References.

Business Insurance Law and Practice Guide, (Matthew Bender).

Business Law Monographs, Volume IN1 —Business Uses of Life Insurance (Matthew Bender Elite Products).

§ 83-18-3. License required to act as administrator; penalties; application; renewal of license; bonding requirements; revocation of license; fines; rules and regulations.

(1) No person shall act as or hold himself out to be an administrator in this state, other than an adjuster licensed in this state for the kinds of business for which he is acting as an adjuster, unless he shall hold a license as an administrator issued by the Mississippi Commissioner of Insurance. Failure to hold such a license shall subject the administrator to a fine of not less than One Hundred Dollars ($100.00) nor more than Five Hundred Dollars ($500.00). Such license shall be issued by the commissioner to an administrator unless the commissioner, after due notice and hearing, shall have determined that the administrator is not competent, trustworthy, financially responsible or of good personal and business reputation or has had a previous application for an insurance license denied for cause within five (5) years.

(2) All applications shall be accompanied by a fee of Two Hundred Dollars ($200.00). The license is renewable annually on the date of issue. A request for renewal must be accompanied by a renewal fee of One Hundred Dollars ($100.00). Prior to the issuance or renewal of the license of any administrator, a fidelity bond in a form and amount as determined by the commissioner shall be obtained by the licensee.

(3) After notice and hearing, the commissioner may revoke a license or fine an administrator not more than Five Hundred Dollars ($500.00), or both, or the commissioner may suspend such license or fine such administrator not more than Five Hundred Dollars ($500.00), or both, upon finding that either

the administrator violated any of the requirements of this chapter or the administrator is not competent, trustworthy, financially responsible or of good personal and business reputation.

(4) The Commissioner of Insurance may promulgate rules and regulations which are necessary to accomplish the purposes of this chapter.

(5) In addition to the reasons specified in this section, the commissioner shall be authorized to suspend the license of any licensee for being out of compliance with an order for support, as defined in Section 93-11-153. The procedure for suspension of a license for being out of compliance with an order for support, and the procedure for the reissuance or reinstatement of a license suspended for that purpose, and the payment of any fees for the reissuance or reinstatement of a license suspended for that purpose, shall be governed by Section 93-11-157 or 93-11-163, as the case may be. Actions taken by the board in suspending a license when required by Section 93-11-157 or 93-11-163 are not actions from which an appeal may be taken under this section. Any appeal of a license suspension that is required by Section 93-11-157 or 93-11-163 shall be taken in accordance with the appeal procedure specified in Section 93-11-157 or 93-11-163, as the case may be, rather than the procedure specified in this section. If there is any conflict between any provision of Section 93-11-157 or 93-11-163 and any provision of this chapter, the provisions of Section 93-11-157 or 93-11-163, as the case may be, shall control.

(6) Each application or filing made under this section shall include the Social Security number(s) of the applicant in accordance with Section 93-11-64, Mississippi Code of 1972.

HISTORY: Laws, 1991, ch. 422, § 2; Laws, 1996, ch. 507, § 88; Laws, 1997, ch. 588, § 70, eff from and after July 1, 1997.

Editor's Notes — Laws of 1997, ch. 588, § 150, provides as follows:

"SECTION 150. Any person or entity shall be absolutely immune from any liability arising from compliance with the dictates of this act unless such conduct by the person or entity is willful and intentional."

Cross References — Certificate of authority required to act as administrator, see § 83-18-23.

RESEARCH REFERENCES

Am. Jur.

1A Am. Jur. Pl & Pr Forms (Rev), Administrative Law, Form 341.2 (complaint, petition, or declaration – by license holder – against administrative agency – to enjoin further proceedings to suspend or revoke license – attempt to suspend or revoke license on grounds not listed in statute authorizing suspension or revocation of license.

§ 83-18-5. Written agreement between administrator and insurer or employer; termination of agreement.

(1) No administrator shall act as such without a written agreement between the administrator and the insurer or employer, and such written agreement shall be retained as part of the official records of both the insurer or

employer and the administrator for the duration of the agreement and for five (5) years thereafter. The agreement shall contain all provisions required by this statute, except insofar as those requirements do not apply to the functions performed by the administrator.

(2) The written agreement shall include a statement of duties which the administrator is expected to perform on behalf of the insurer or employer and the lines, classes or types of insurance for which the administrator is to be authorized to administer. The agreement shall make provision with respect to underwriting or other standards pertaining to the business underwritten by such insurer.

(3) The insurer, employer or administrator may, with written notice, terminate the written agreement for cause as provided in the agreement. The insurer may suspend the underwriting authority of the administrator during the pendency of any dispute regarding the cause for termination of the written agreement. The insurer must fulfill any lawful obligations with respect to policies affected by the written agreement, regardless of any dispute between the insurer and the administrator.

HISTORY: Laws, 1991, ch. 422, § 3, eff from and after July 1, 1991.

Cross References — Additional requirements of written agreement, see § 83-18-15.

§ 83-18-7. Payments to administrator deemed received by insurer; payments to administrator not deemed paid to insured or claimant until received by insured or claimant.

If an insurer utilizes the services of an administrator, the payment to the administrator of any premiums or charges for insurance by or on behalf of the insured party shall be deemed to have been received by the insurer, and the payment of return premiums or claim payments forwarded by the insurer to the administrator shall not be deemed to have been paid to the insured party or claimant until such payments are received by the insured party or claimant. Nothing in this section limits any right of the insurer against the administrator resulting from the failure of the administrator to make payments to the insurer, insured parties or claimants.

HISTORY: Laws, 1991, ch. 422, § 4, eff from and after July 1, 1991.

§ 83-18-9. Record keeping requirements.

(1) Every administrator shall maintain and make available to the insurer or employer complete books and records of all transactions performed on behalf of the insurer or employer. The books and records shall be maintained in accordance with prudent standards of insurance record keeping and must be maintained for a period of not less than five (5) years from the date of their creation.

(2) The commissioner shall have access to books and records maintained by an administrator for the purposes of examination, audit and inspection. Any trade secrets contained in such books and records, including the identity and addresses of policyholders and certificate holders, shall be kept confidential, except that the commissioner may use such information in any proceeding instituted against the administrator.

(3) The insurer or employer shall own the records generated by the administrator pertaining to the insurer; however, the administrator shall retain the right to continuing access to books and records to permit the administrator to fulfill all of its contractual obligations to insured parties, claimants, and the insurer.

(4) In the event the insurer or employer and the administrator cancel their agreement, notwithstanding the provisions of subsection (1) of this section, the administrator may, by written agreement with the insurer or employer, transfer all records to a new administrator rather than retain them for five (5) years. In such cases, the new administrator shall acknowledge, in writing, that it is responsible for retaining the records of the prior administrator as required in subsection (1) of this section.

HISTORY: Laws, 1991, ch. 422, § 5, eff from and after July 1, 1991.

§ 83-18-11. Advertising by administrator.

An administrator may use only such advertising pertaining to the business underwritten by an insurer as has been approved in writing by the insurer in advance of its use.

HISTORY: Laws, 1991, ch. 422, § 6, eff from and after July 1, 1991.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 47.

§ 83-18-13. Responsibilities of insurer utilizing services of administrator.

(1) If an insurer utilizes the services of an administrator, the insurer shall be responsible for determining the benefits, premium rates, underwriting criteria and claims payment procedures applicable to such coverage and for securing reinsurance, if any. The rules pertaining to these matters must be provided, in writing, by the insurer to the administrator. The responsibilities of the administrator as to any of these matters shall be set forth in the written agreement between the administrator and the insurer.

(2) It is the sole responsibility of the insurer or employer to provide for competent administration of its programs.

(3) In cases where an administrator benefits for more than one hundred (100) certificate holders on behalf of an insurer, the insurer shall, at least

semiannually, conduct a review of the operations of the administrator. At least one (1) such review shall be an on-site audit of the operations of the administrator.

HISTORY: Laws, 1991, ch. 422, § 7, eff from and after July 1, 1991.

§ 83-18-15. Administrator's duties as fiduciary for insurer.

(1) All insurance charges or premiums collected by an administrator on behalf of or for an insurer or insurers, and the return of premiums received from that insurer or insurers, shall be held by the administrator in a fiduciary capacity. Such funds shall be immediately remitted to the person or persons entitled to them or shall be deposited promptly in a fiduciary account established and maintained by the administrator in a federally insured financial institution. The written agreement between the administrator and the insurer shall provide for the administrator to periodically render an accounting to the insurer detailing all transactions performed by the administrator pertaining to the business underwritten by the insurer.

(2) If charges or premiums deposited in a fiduciary account have been collected on behalf of or for one or more insurers, the administrator shall keep records clearly recording the deposits in and withdrawals from the account on behalf of each insurer. The administrator shall keep copies of all the records, and upon request of an insurer, shall furnish the insurer with copies of the records pertaining to such deposits and withdrawals.

(3) The administrator shall not pay any claim by withdrawals from a fiduciary account in which premiums or charges are deposited. Withdrawals from such account shall be made as provided in the written agreement between the administrator and the insurer. The written agreement shall address, but not be limited to, the following:

(a) Remittance to an insurer entitled to remittance;

(b) Deposit in an account maintained in the name of the insurer;

(c) Transfer to and deposit in a claims-paying account, with claims to be paid as provided in subsection (4);

(d) Payment to a group policyholder for remittance to the insurer entitled to such remittance;

(e) Payment to the administrator of its commissions, fees or charges; and

(f) Remittance of return premium to the person or persons entitled to such return premium.

(4) All claims paid by the administrator from funds collected on behalf of or for an insurer shall be paid only on drafts or checks of and as authorized by the insurer.

HISTORY: Laws, 1991, ch. 422, § 8, eff from and after July 1, 1991.

Cross References — Written agreement between administrator and insurer, see § 83-18-5.

§ 83-18-17. Administrator's compensation not to be contingent on claim experience.

(1) An administrator shall not enter into any agreement or understanding with an insurer in which the effect is to make the amount of the administrator's commissions, fees or charges contingent upon savings effected in the adjustment, settlement and payment of losses covered by the insurer's obligations. This provision shall not prohibit an administrator from receiving performance-based compensation for providing hospital or other auditing services.

(2) This section shall not prevent the compensation of an administrator from being based on premiums or charges collected or the number of claims paid or processed.

HISTORY: Laws, 1991, ch. 422, § 9, eff from and after July 1, 1991.

§ 83-18-19. Disclosure requirements of administrator.

(1) When the services of an administrator are utilized, the administrator shall provide a written notice approved by the insurer to covered individuals advising them of the identity of, and relationship among, the administrator, the policyholder and the insurer.

(2) When an administrator collects funds, the reason for collection of each item must be identified to the insured party and each item must be shown separately from any premium. Additional charges may not be made for services to the extent the services have been paid for by the insurer.

(3) The administrator shall disclose to the insurer or employer all charges, fees and commissions received from all services in connection with the provision of administrative services for the insurer, including any fees or commissions paid by insurers providing reinsurance.

HISTORY: Laws, 1991, ch. 422, § 10, eff from and after July 1, 1991.

§ 83-18-21. Administrator to deliver written notices from insurer promptly.

Any policies, certificates, booklets, termination notices or other written communications delivered by the insurer to the administrator for delivery to insured parties or covered individuals shall be delivered by the administrator promptly after receipt of instructions from the insurer to deliver them.

HISTORY: Laws, 1991, ch. 422, § 11, eff from and after July 1, 1991.

§ 83-18-23. Certificate of authority required to act as administrator; application; additional requirements; exceptions.

(1) No person shall act as, or offer to act as, or hold himself out to be an

administrator in this state without a valid certificate of authority as an administrator issued by the commissioner.

(2) Applicants to be an administrator shall make an application to the commissioner upon a form to be furnished by the commissioner. The application shall include or be accompanied by the following information and documents:

(a) All basic organizational documents of the administrator, including any articles of incorporation, articles of association, partnership agreement, trade name certificate, trust agreement, shareholder agreement and other applicable documents and all amendments to such documents;

(b) The bylaws, rules, regulations or similar documents regulating the internal affairs of the administrator;

(c) The names, addresses, official positions and professional qualifications of the individuals who are responsible for the conduct of affairs of the administrator; including all members of the board of directors, board of trustees, executive committee or other governing board or committee; the principal officers in the case of a corporation or the partners or members in the case of a partnership or association; shareholders holding directly or indirectly ten percent (10%) or more of the voting securities of the administrator; and any other person who exercises control or influence over the affairs of the administrator;

(d) Annual financial statements or reports for the two (2) most recent years which prove that the applicant is solvent and such information as the commissioner may require in order to review the current financial condition of the applicant;

(e) A statement describing the business plan including information on staffing levels and activities proposed in this state and nationwide. The plan must provide details setting forth the administrator's capability for providing a sufficient number of experienced and qualified personnel in the areas of claims processing, record keeping and underwriting;

(f) If the applicant will be managing the solicitation of new or renewal business, proof that it employs or has contracted with an agent licensed by this state for solicitation and taking of applications. Any applicant which intends to directly solicit insurance contracts or to otherwise act as an insurance agent must provide proof that it has a license as an insurance agent in this state;

(g) Such other pertinent information as may be required by the commissioner.

(3) The applicant shall make available for inspection by the commissioner copies of all contracts with insurers or other persons utilizing the services of the administrator.

(4) The commissioner may refuse to issue a certificate of authority if the commissioner determines that the administrator, or any individual responsible for the conduct of affairs of the administrator as defined in subsection (2)(c) of this section, is not competent, trustworthy, financially responsible or of good personal and business reputation, or has had an insurance or an administrator license denied or revoked for cause by any state.

(5) A certificate of authority issued under this section shall remain valid, unless surrendered, suspended or revoked by the commissioner, for so long as the administrator continues in business in this state and remains in compliance with this chapter.

(6) An administrator is not required to hold a certificate of authority as an administrator in this state if all of the following conditions are met:

(a) The administrator is not soliciting business as an administrator in this state;

(b) In the case of any group policy or plan of insurance serviced by the administrator, the lesser of five percent (5%) or one hundred (100) certificate holders reside in this state.

(7) An administrator shall immediately notify the commissioner of any material change in its ownership, control or other fact or circumstance affecting its qualification for a certificate of authority in this state.

(8) No bonding shall be required by the commissioner of any administrator whose business is restricted solely to benefit plans which are either fully insured by an authorized insurer or which are bona fide employee benefit plans established by an employer or any employee organization, or both, for which the insurance laws of this state are preempted pursuant to the Employee Retirement Income Security Act of 1974.

HISTORY: Laws, 1991, ch. 422, § 12, eff from and after July 1, 1991.

Cross References — Licensing requirements to act as administrator, see § 83-18-3.
Grounds for waiver of application requirements of this section, see § 83-18-25.

Federal Aspects — Employee Retirement Income Security Act of 1974, see generally 29 USCS § 1001 et seq.

§ 83-18-25. Waiver of application requirements where administrator certified in another state.

Upon request from an administrator, the commissioner may waive the application requirements of subsection (2) of Section 83-18-23 if the administrator has a valid certificate of authority as an administrator issued in a state which has standards for administrators that are at least as stringent as those contained in the model statute for third-party administrators of the National Association of Insurance Commissioners.

HISTORY: Laws, 1991, ch. 422, § 13, eff from and after July 1, 1991.

§ 83-18-27. Annual report of administrators.

(1) Each administrator shall file an annual report for the preceding calendar year with the commissioner on or before March 1 of each year, or within such extension of time therefor as the commissioner for good cause may grant. The report shall be in the form and contain such matters as the commissioner prescribes and shall be verified by at least two (2) officers of the administrator.

(2) The annual report shall include the complete names and addresses of all insurers with which the administrator had an agreement during the preceding fiscal year.

(3) At the time of filing its annual report, the administrator shall pay a filing fee as required by the commissioner.

HISTORY: Laws, 1991, ch. 422, § 14, eff from and after July 1, 1991.

§ 83-18-29. Suspension or revocation of certificate of authority; fine in lieu of suspension or revocation.

(1) The certificate of authority of an administrator shall be suspended or revoked if the commissioner finds that the administrator:

(a) Is in an unsound financial condition;

(b) Is using such methods or practices in the conduct of its business so as to render its further transaction of business in this state hazardous or injurious to insured persons or the public; or

(c) Has failed to pay any judgment rendered against it in this state within sixty (60) days after the judgment has become final.

(2) The commissioner may, in his or her discretion, suspend or revoke the certificate of authority of an administrator if the commissioner finds that the administrator:

(a) Has violated any lawful rule or order of the commissioner or any provision of the insurance laws of this state;

(b) Has refused to be examined or to produce its accounts, records and files for examination, or if any of its officers has refused to give information with respect to its affairs or has refused to perform any other legal obligation as to such examination, when required by the commissioner;

(c) Has, without just cause, refused to pay proper claims or perform services arising under its contracts or has, without just cause, caused covered individuals to accept less than the amount due them or caused covered individuals to employ attorneys or bring suit against the administrator to secure full payment or settlement of such claims;

(d) Is affiliated with or under the same general management or interlocking directorate or ownership as another administrator or insurer which unlawfully transacts business in this state without having a certificate of authority;

(e) At any time fails to meet any qualification for which issuance of the certificate could have been refused had such failure then existed and been known to the department;

(f) Has been convicted of, or has entered a plea of guilty or nolo contendere to, a felony without regard to whether adjudication was withheld; or

(g) Is under suspension or revocation in another state.

(3) The commissioner may, in his or her discretion and without advance notice or hearing thereon, immediately suspend the certificate of any administrator if the commissioner finds that one or more of the following circumstances exist:

(a) The administrator is insolvent or impaired;

(b) A proceeding for receivership, conservatorship, rehabilitation or other delinquency proceeding regarding the administrator has been commenced in any state;

(c) The financial condition or business practices of the administrator otherwise pose an imminent threat to the public health, safety or welfare of the residents of this state.

(4) If the commissioner finds that one or more grounds exist for the suspension or revocation of a certificate of authority issued under this chapter, the commissioner may, in lieu of such suspension or revocation, impose a fine upon the administrator.

HISTORY: Laws, 1991, ch. 422, § 15, eff from and after July 1, 1991.

MANAGING GENERAL AGENTS ACT

Sec.

83-18-101. Short title.
83-18-103. Definitions.
83-18-105. License required to act as managing general agent; bonding requirement; rules and regulations.
83-18-107. Written contract required to place business with insurer; minimum contents of contract; claim files; termination or suspension of settlement authority; payment of interim profits to agent; prohibited acts of managing general agent.
83-18-109. Duties and responsibilities of insurer with respect to each managing general agent it does business with; acts of managing general agent considered acts of insurer.
83-18-111. Penalties for violations; judicial review; rights of policyholders and others not restricted.

§ 83-18-101. Short title.

Sections 83-18-101 through 83-18-111 may be cited as the Managing General Agents Act.

HISTORY: Laws, 1992, ch. 329, § 1, eff from and after July 1, 1992.

RESEARCH REFERENCES

Am. Jur.

44A Am. Jur. 2d, Insurance §§ 1809-1825.

Practice References.

Business Insurance Law and Practice Guide (Matthew Bender Elite Products).

Business Law Monographs (Matthew Bender Elite Products).

Liability of Corporate Officers and Directors, William E. Knepper, Dan A. Bailey, Stacy R. Lane, Katharine B. Bowman, Michael R. Goodstein, Darius N. Kandawalla (Matthew Bender).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-18-103. Definitions.

As used in Sections 83-18-101 through 83-18-111:

(a) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

(b) "Insurer" means any person, firm, association or corporation duly licensed in this state as an insurance company as defined in Section 83-5-1, Mississippi Code of 1972.

(c) "Managing general agent" means any person, firm, association or corporation who negotiates and binds ceding reinsurance contracts on behalf of an insurer or manages all or part of the insurance business of an insurer (including the management of a separate division, department or underwriting office) and acts as an agent for such insurer whether known as a managing general agent, manager or other similar term, who, with or without the authority, either separately or together with affiliates, produces, directly or indirectly, and underwrites an amount of gross direct written premium equal to or more than five percent (5%) of the policyholder surplus as reported in the last annual statement of the insurer in any one (1) quarter or year together with one or more of the following: (i) adjusts or pays claims in excess of an amount determined by the commissioner; or (ii) negotiates reinsurance on behalf of the insurer.

Notwithstanding the above, the following persons shall not be considered as a managing general agent for the purposes of Sections 83-18-101 through 83-18-111:

(i) An employee of the insurer;

(ii) A United States manager of the United States branch of an alien insurer;

(iii) An underwriting manager which, pursuant to contract, manages all the insurance operations of the insurer, is under common control with the insurer, subject to the holding company regulatory act, and whose compensation is not based on the volume of premiums written; or

(iv) The attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer or interinsurance exchange under powers of attorney.

(d) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

HISTORY: Laws, 1992, ch. 329, § 2, eff from and after July 1, 1992.

Cross References — Insurer to review its books and records quarterly to determine if producer has become, by operation of this section, a managing general agent, see § 83-18-109.

§ 83-18-105. License required to act as managing general agent; bonding requirement; rules and regulations.

(1) No person, firm, association or corporation shall act in the capacity of a managing general agent with respect to risks located in this state for an

insurer licensed in this state unless such person is a licensed producer in this state.

(2) No person, firm, association or corporation shall act in the capacity of a managing general agent representing an insurer domiciled in this state with respect to risks located outside this state unless such person is licensed as a producer in this state (such license may be a nonresident license) under Sections 83-18-101 through 83-18-111.

(3) The commissioner may require a bond in an amount acceptable to him for the protection of the insurer. The commissioner may require the managing general agent to maintain an errors and omissions policy.

(4) The commissioner may adopt reasonable rules and regulations to implement Sections 83-18-101 through 83-18-111.

HISTORY: Laws, 1992, ch. 329, § 3, eff from and after July 1, 1992.

RESEARCH REFERENCES

Am. Jur.
44A Am. Jur. 2d, Insurance §§ 1809-1825.

§ 83-18-107. Written contract required to place business with insurer; minimum contents of contract; claim files; termination or suspension of settlement authority; payment of interim profits to agent; prohibited acts of managing general agent.

(1) No person, firm, association or corporation acting in the capacity of a managing general agent shall place business with an insurer unless there is in force a written contract between the parties which sets forth the responsibilities of each party and where both parties share responsibility for a particular function, specifies the division of such responsibilities and which contains the following minimum provisions:

(a) The insurer may terminate the contract for cause upon written notice to the managing general agent. The insurer may suspend the underwriting authority of the managing general agent during the pendency of any dispute regarding the cause for termination.

(b) The managing general agent will render accounts to the insurer detailing all transactions and remit all funds due under the contract to the insurer on not less than a monthly basis.

(c) All funds collected for the account of an insurer will be held by the managing general agent in a fiduciary capacity in a bank which is a member of the Federal Reserve System. This account shall be used for all payments on behalf of the insurer. The managing general agent may retain no more than three (3) months estimated claims payments and allocated loss adjustment expenses.

(d) Separate records of business written by the managing general agent shall be maintained. The insurer shall have access and right to copy all accounts and records related to its business in a form usable by the insurer and the commissioner shall have access to all books, bank accounts and records of the managing general agent in a form usable to the commissioner.

(e) The contract may not be assigned in whole or part by the managing general agent.

(f) Appropriate underwriting guidelines including:

(i) The maximum annual premium volume;
(ii) The basis of the rates to be charged;
(iii) The types of risks which may be written;
(iv) Maximum limits of liability;
(v) Applicable exclusions;
(vi) Territorial limitations;
(vii) Policy cancellation provisions; and
(viii) The maximum policy period.

The insurer shall have the right to cancel or nonrenew any policy of insurance subject to the applicable laws and regulations.

(g) If the contract permits the managing general agent to settle claims on behalf of the insurer:

(i) All claims must be reported to the company in a timely manner.

(ii) A copy of the claim file shall be sent to the insurer at its request or as soon as it becomes known that the claim:

(A) Has the potential to exceed an amount determined by the commissioner or exceeds the limit set by the company, whichever is less;

(B) Involves a coverage dispute;

(C) May exceed the managing general agent's claims settlement authority;

(D) Is open for more than six (6) months; or

(E) Is closed by payment of an amount set by the commissioner or an amount set by the company, whichever is less.

(h) Where electronic claims files are in existence, the contract must address the timely transmission of the data.

(2) All claim files shall be the joint property of the insurer and managing general agent. However, upon an order of liquidation of the insurer such files shall become the sole property of the insurer or its estate; the managing general agent shall have reasonable access to and the right to copy the files on a timely basis.

(3) Any settlement authority granted to the managing general agent may be terminated for cause upon the insurer's written notice to the managing general agent or upon the termination of the contract. The insurer may suspend the settlement authority during the pendency of any dispute regarding the cause for termination.

(4) If the contract provides for a sharing of interim profits by the managing general agent, and the managing general agent has the authority to determine the amount of the interim profits by establishing loss reserves or controlling claim payments, or in any other manner, interim profits shall not be paid to the managing general agent until one (1) year after they are earned

for property insurance business and five (5) years after they are earned on casualty business and not until the profits have been verified pursuant to Section 83-18-109.

(5) The managing general agent shall not:

(a) Bind reinsurance or retrocessions on behalf of the insurer, except that the managing general agent may bind facultative reinsurance contracts pursuant to obligatory facultative agreements if the contract with the insurer contains reinsurance underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules;

(b) Commit the insurer to participate in insurance or reinsurance syndicates;

(c) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of insurance for which he is appointed;

(d) Without prior approval of the insurer, pay or commit the insurer to pay a claim over a specified amount, net of reinsurance, which shall not exceed one percent (1%) of the insurer's policyholder's surplus as of December 31 of the last completed calendar year;

(e) Collect any payment from a reinsurer or commit the insurer to any claim settlement with a reinsurer without prior approval of the insurer. If prior approval is given, a report must be promptly forwarded to the insurer;

(f) Permit its subproducer to serve on the insurer's board of directors;

(g) Jointly employ an individual who is employed with the insurer; or

(h) Appoint a submanaging general agent.

HISTORY: Laws, 1992, ch. 329, § 4, eff from and after July 1, 1992.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected typographical errors in paragraph (a) of subsection (5). The word "faculative" was changed to "facultative" in two places. The Joint Committee ratified the correction at its December 3, 1996 meeting.

RESEARCH REFERENCES

ALR.

Duty of liability insurer to initiate settlement negotiations. 51 A.L.R.5th 701.

Am. Jur.

44A Am. Jur. 2d, Insurance §§ 1809-1825.

§ 83-18-109. Duties and responsibilities of insurer with respect to each managing general agent it does business with; acts of managing general agent considered acts of insurer.

(1) The insurer shall have on file an independent financial examination, in a form acceptable to the commissioner, of each managing general agent with which it has done business.

(2) If a managing general agent establishes loss reserves, the insurer

shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the managing general agent. This is in addition to any other required loss reserve certification.

(3) The insurer shall periodically (at least semiannually) conduct an on-site review of the underwriting and claims processing operations of the managing general agent.

(4) Binding authority for all reinsurance contracts or participation in insurance or reinsurance syndicates shall rest with an officer of the insurer, who shall not be affiliated with the managing general agent.

(5) Within thirty (30) days of entering into or termination of a contract with a managing general agent, the insurer shall provide written notification of such appointment or termination to the commissioner. Notices of appointment of a managing general agent shall include a statement of duties which the applicant is expected to perform on behalf of the insurer, the lines of insurance for which the applicant is to be authorized to act and any other information the commissioner may request.

(6) An insurer shall review its books and records each quarter to determine if any producer as defined by Section 83-18-103 has become, by operation of Section 83-18-103, a managing general agent as defined in that section. If the insurer determines that a producer has become a managing general agent pursuant to the above, the insurer shall promptly notify the producer and the commissioner of such determination and the insurer and producer must fully comply with the provisions of Sections 83-18-101 and 83-18-111 within thirty (30) days.

(7) An insurer shall not appoint to its board of directors an officer, director, employee, subproducer or controlling shareholder of its managing general agent. This subsection shall not apply to relationships governed by the Insurance Holding Company Act or, if applicable, the Broker Controlled Insurer Act.

(8) The acts of the managing general agent are considered to be the acts of the insurer on whose behalf it is acting. A managing general agent may be examined as if it were the insurer.

HISTORY: Laws, 1992, ch. 329, § 5, eff from and after July 1, 1992.

Cross References — Payment of interim profits to managing general agent not to be made until profits have been verified pursuant to this section, see § 83-18-107.

RESEARCH REFERENCES

Am. Jur.
44A Am. Jur. 2d, Insurance §§ 1809-1825.

§ 83-18-111. Penalties for violations; judicial review; rights of policyholders and others not restricted.

(1) If the commissioner finds after a hearing conducted in accordance with Section 83-6-39, Mississippi Code of 1972, that any person has violated Sections 83-18-101 through 83-18-111, the commissioner may order:

(a) For each separate violation, a penalty in an amount not to exceed Five Hundred Dollars ($500.00);

(b) Revocation or suspension of the producer's license; and

(c) The managing general agent to reimburse the insurer, the rehabilitator or liquidator of the insurer for any losses incurred by the insurer caused by a violation of Sections 83-18-101 through 83-18-111 committed by the managing general agent.

(2) The decision, determination or order of the commissioner pursuant to subsection (1) shall be subject to judicial review pursuant to Section 83-6-41, Mississippi Code of 1972.

(3) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the insurance law.

(4) Nothing contained in Sections 83-18-101 through 83-18-111 is intended to or shall in any manner limit or restrict the rights of policyholders, claimants and auditors.

HISTORY: Laws, 1992, ch. 329, § 6, eff from and after July 1, 1992.

CHAPTER 19.

DOMESTIC COMPANIES

General Provisions. 83-19-1
Merger or Consolidation, or Exchange of Outstanding Stock, of Domestic Stock Companies. 83-19-99
Regulation of Reinsurance. 83-19-151
Reinsurance Intermediary Act. 83-19-201

GENERAL PROVISIONS

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§ 83-19-1. Classifications of insurance companies.

Insurance companies may be formed for the following classifications:

Class 1. Fire and Casualty.

(a) **Fire and Allied Lines.** Coverage protecting against loss to real or personal property from damage caused by the peril of fire, lightning, windstorm and hail, sprinkler and water damage, smoke, explosion, riot, riot attending strike, civil commotion, aircraft, vehicle and business interruption caused by one (1) of the above.

(b) **Industrial Fire.** Limited coverage protecting against loss to real or personal property from damage caused by the peril of fire, lightning, windstorm and hail, sprinkler and water damage, smoke, explosion, riot, riot attending strike, civil commotion, aircraft, vehicle, burglary, theft and business interruption caused by one (1) of the above.

(c) **Casualty/Liability.** Coverage protecting the insured against legal liability resulting from negligence, carelessness or a failure to act causing property damage or personal injury to others. Coverage may include burglary and theft.

(d) **Fidelity.** A bond covering an employer's loss resulting from an employee's dishonest act.

(e) **Surety.** A three-party agreement where the insurer agrees to pay a second party (the obligee) or make complete an obligation in response to the default, acts or omissions of a third party (the principal).

(f) **Workers' Compensation.** Coverage for an employer's liability for injuries, disability or death to persons in their employment, without regard to fault, as prescribed by state workers' compensation laws.

(g) **Boiler and Machinery.** Coverage for the failure of boilers, machinery and electrical equipment.

(h) **Plate Glass.** Coverage for the cost of replacement and incidental cost of building glass due to breakage or application of chemicals to glass.

(i) **Aircraft.** Coverage for aircraft (hull) and contents; aircraft owner's and manufacturer's liability to passengers, airports and other third parties.

(j) **Inland Marine.** Coverage for inland transportation exposures, property in transit, held by a bailee, scheduled, bridges and tunnels.

(k) **Ocean Marine.** Coverage for ocean and inland water transportation exposures; goods or cargoes; ships or hulls.

(*l*) **Automobile Physical Damage/Automobile Liability.** Coverage protecting against loss to owner's vehicle, personal injury and damage to property of others.

(m) **Homeowners/Farmowners.** A package policy covering real and personal property, liability and theft.

(n) **Guaranty.** An indemnity contract under which loss is payable upon proof of occurrence of financial loss to an insured claimant, obligee or indemnitee as a result of failure to perform a financial obligation.

(o) **Mortgage Guaranty.** Coverage indemnifying a lender from loss when a borrower fails to meet required mortgage payments.

(p) **Title.** Coverage protecting the insured against risk resulting from defective titles or invalidity or adverse claim to title.

(q) **Trip Accident and Baggage.** Coverage protecting the insured against risk resulting from accidental death; loss or damage to personal effects carried as baggage in connection with transportation provided by a common carrier.

(r) **Legal.** Coverage protecting the insured against the risk resulting from the cost of legal services.

(s) **Credit Property.** Insurance against loss of or damage to personal property purchased through a credit transaction or used as collateral for a credit transaction.

Class 2. Life.

(a) **Life.** Insurance contract for the payment of endowments or annuities, or make and enter into such other contracts conditioned upon the continuance or cessation of human life.

(b) **Accident and Health.** Individual or group policy or contract of insurance against loss resulting from sickness or bodily injury, including dental care expenses resulting from sickness or bodily injury, or death by accident, or accidental means, or both.

(c) **Credit Life, Credit Accident and Health.** Insurance on the life of a debtor in connection with a specific loan or other credit transactions; insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy.

(d) **Industrial Life, Industrial Accident and Health.** Limited insurance coverage protecting the insured in case of death, bodily injury or disability.

(e) **Variable Contracts.** Contract which provides for variable life insurance or annuity benefits which may vary according to the investment experience of any separate account or accounts maintained by the insurer as to such contract.

(f) **Life (Burial).** A limited life contract for payment of the burial expenses of the insured.

Class 3. Fraternal.

(a) **Fraternal.** Coverage for the mutual benefit of fraternal members and their beneficiaries and not for profit or which limits its membership to a secret fraternity having a lodge system and representative form of government. Benefits may be paid in case of death, disability, funeral expenses, monuments or tombstones.

(b) **Larger Fraternal.** Coverage for the mutual benefit of larger fraternal members and their beneficiaries and not for profit or which limits its membership to a secret fraternity having a lodge system and representative form of government. Benefits may be paid in case of death, endowment, annuity, temporary or permanent disability; hospital, medical or nursing; funeral, monument or tombstone and such other benefits as authorized for life insurers. For purposes of this paragraph (b), "larger fraternal" means those fraternal societies that have more than Thirty Thousand Dollars ($30,000.00) in total annual written premiums.

Class 4. Burial. Insurance coverage protecting the insured against the risk resulting from the cost of burial expenses.

HISTORY: Codes, 1892, § 2332; 1906, § 2576; Hemingway's 1917, § 5040; 1930, § 5144; 1942, § 5654; Laws, 1928, ch. 127; Laws, 1997, ch. 410, § 11; Laws, 2002, ch. 392, § 1; Laws, 2004, ch. 523, § 1; Laws, 2008, ch. 326, § 1; Laws, 2010, ch. 450, § 1, eff from and after July 1, 2010.

Cross References — Registration and examination of companies writing casualty insurance, ordinary life insurance or health and accident insurance, see §§ 83-6-1 et seq.

Capital required for various classes of companies, see § 83-19-31.

Investment of funds by domestic insurance companies, see § 83-19-51.

Kind of insurance authorized for mutual companies, see § 83-31-11.

Legal expense insurance, see §§ 83-49-1 et seq.

Application of venue provisions of §§ 83-19-1 et seq. to legal expense insurance plan sponsors, see § 83-49-33.

JUDICIAL DECISIONS

1. In general.

Policy including both death benefit and health and accident disability constituted "life insurance policy." Universal Life Ins. Co. v. State, 155 Miss. 358, 121 So. 849, 1929 Miss. LEXIS 258 (Miss. 1929).

Held duty of insurer of animals to furnish form for making proof of loss in conformity with policy. Atlantic Horse Ins. Co. v. Nero, 108 Miss. 321, 66 So. 780, 1914 Miss. LEXIS 208 (Miss. 1914).

Insured under accident policy, who had changed to more hazardous occupation and was killed while off duty, held entitled to only such indemnity as premium paid would purchase at rate charged for more hazardous occupation. Beane v. Continental Casualty Co., 106 Miss. 813, 64 So. 732, 1914 Miss. LEXIS 21 (Miss. 1914).

Stipulation in employer's liability policy that no claim could be paid insured without written consent of insurer could be waived by parol. London Guarantee & Acci. Co. v. Mississippi C. R. Co., 97 Miss. 165, 52 So. 787, 1910 Miss. LEXIS 273 (Miss. 1910).

RESEARCH REFERENCES

ALR.

What constitutes "upset" or "overturning" within provisions of property damage policy covering losses so caused. 8 A.L.R.2d 1433.

What constitutes "granary" within provisions of fire insurance policy covering articles therein. 10 A.L.R.2d 226.

What constitutes "farm use" within provision of insurance policy. 10 A.L.R.2d 674.

Damage to vehicle resulting from wind or other phenomenon of nature as within coverage of automobile insurance policy insuring against collision or upset. 14 A.L.R.2d 812.

Construction and application of provision of life or accident policy relating to aeronautics. 17 A.L.R.2d 1041.

Rent loss insurance. 17 A.L.R.2d 1226.

Construction of clause of automobile liability policy excluding coverage in case of "commercial" use. 18 A.L.R.2d 719.

Apportionment of losses among automobile liability insurers under policies containing pro rata clauses. 21 A.L.R.2d 611.

Recovery under automobile property damage policy expressly including or excluding collision damage, where vehicle strikes embankment, abutment, roadbed, or other part of highway. 23 A.L.R.2d 389.

Vehicles and operations covered by automobile dealer's collision insurance policy. 23 A.L.R.2d 796.

Scope of clause of insurance policy covering injuries sustained from being "accidentally thrown from" a vehicle. 24 A.L.R.2d 1454.

Construction in effect of clause in liability policy voiding policy while insured vehicles are being used more than a specified distance from principal garage. 29 A.L.R.2d 514.

Automobile liability insurance: conditional vendee of insured as within coverage of omnibus clause. 36 A.L.R.2d 673.

Construction and effect of provision in employee's fidelity bond requiring employer-insured to file "itemized" proof of claim or proof of loss with particulars. 37 A.L.R.2d 900.

Scope of clause of insurance policy covering injuries sustained while "in or on" or "in or upon" motor vehicle. 39 A.L.R.2d 952.

Measure of recovery by insured under automobile collision insurance policy. 43 A.L.R.2d 327.

Determination of amount payable on loss to growing crop under policy insuring against loss or injury. 20 A.L.R.3d 924.

What constitutes "vandalism" or "malicious mischief" within automobile comprehensive coverage policy. 23 A.L.R.3d 1259.

Theft insurance: coverage of expense of reward offered by insured, or other expense incurred in recovering stolen property. 46 A.L.R.3d 403.

Property insurance on aircraft: risks and losses covered. 48 A.L.R.3d 1120.

"Vehicle" or "land vehicle" within meaning of insurance policy provision defining risks covered or excepted. 65 A.L.R.3d 824.

Fidelity bond termination clause on taking over of insured by another business entity: construction and effect. 44 A.L.R.4th 1195.

Boiler and machinery insurance: risks and losses covered by policy or provision expressly covering boilers and machinery. 49 A.L.R.4th 336.

What constitutes "entering" or "alighting from" vehicle within meaning of insurance policy, or statute mandating insurance coverage. 59 A.L.R.4th 149.

Construction and effect of "rain insurance" policies insuring against rainfall on the date of concert, exhibition, game, or the like. 70 A.L.R.4th 1010.

Property damage insurance: what constitutes "contamination" within policy clause excluding coverage. 72 A.L.R.4th 633.

Liability of owner of wires, poles, or structures struck by aircraft for resulting injury or damage. 49 A.L.R.5th 659.

Liability for loss of hat, coat, or other property deposited by customer in place of business. 54 A.L.R.5th 393.

Property Damage Insurance: What Constitutes "Contamination" Within Policy Clause Excluding Coverage.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 105, 106.
47 Am. Jur. Trials 411, Handling Fidelity Bond Claims.
5 Am. Jur. Proof of Facts 3d, Negligent Failure to Install or Maintain Smoke Alarm or Sprinkler System §§ 1 et seq.

CJS.
44 C.J.S., Insurance §§ 147, 148.

Practice References.
Business Insurance Law and Practice Guide (Matthew Bender Elite Products).

§ 83-19-3. Insurance of apparatus.

All insurance companies authorized to transact fire insurance business in this state may, in addition to the business which they are now authorized by law to do, insure sprinklers, pumps, and other apparatus erected or put in position for the purpose of extinguishing fires, against damage, loss, or injury resulting from accidental causes other than fire; and also insure any property which such companies are authorized to insure against loss or damage by fire against damage, loss, or injury by water or otherwise, resulting from the accidental breaking off or injury to sprinklers, pumps, or other apparatus arising from causes other than fire.

HISTORY: Codes, 1906, § 2577; Hemingway's 1917, § 5041; 1930, § 5145; 1942, § 5655; Laws, 1954, ch. 310.

RESEARCH REFERENCES

Am. Jur.
44 Am. Jur. 2d, Insurance § 1435.
5 Am. Jur. Proof of Facts 3d, Negligent Failure to Install or Maintain Smoke Alarm or Sprinkler System §§ 1 et seq.

CJS.
45 C.J.S., Insurance § 1249.

§ 83-19-5. Expiration of charters under special acts.

Domestic insurance companies, incorporated by special acts, whose charters are subject to limitation of time shall, after such limitation expires, continue to be bodies corporate, subject to all general laws applicable to such companies. No domestic insurance company hereafter organized shall issue policies until, upon examination of the commissioner, his deputy, or examiner, it is found to have complied with the laws of the state, nor until it has obtained from the commissioner a certificate setting forth that fact and authorizing it to issue policies.

HISTORY: Codes, 1906, § 2572; Hemingway's 1917, § 5037; 1930, § 5141; 1942, § 5651.

Cross References — Capital stock requirement before issuance of policies, see § 83-19-33.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-19-7. Expiration of charters under general insurance laws.

Domestic insurance companies incorporated under the general insurance laws whose charters are subject to limitation of time and who shall, after such limitation expires, continue to do business for ninety (90) days after March 6, 1956, shall be deemed to have accepted an extension of the time of life of such insurance corporation to a full period of ninety-nine (99) years from the date of the original charter thereof.

Such insurance corporation shall continue in existence as a de jure corporation as fully and completely as if the charter thereof had been thus amended prior to the end of the original period of fifty (50) years.

Likewise, whenever the period of existence of a domestic insurance company heretofore created for a period of fifty (50) years shall expire hereafter, if such corporation shall continue to do business thereafter for a period of ninety (90) days, the same shall operate as an acceptance of an extension of time of the life of such insurance corporation to a full period of ninety-nine (99) years from the date of the original charter thereof, and such insurance corporation shall continue in existence as a de jure corporation as fully and completely as if the charter thereof had been thus amended prior to the end of the original period of fifty (50) years.

Provided, however, that the provisions of this section shall in no way, shape, form, or fashion abate or nullify any suit or claim of whatsoever kind or nature accrued prior to March 6, 1956.

HISTORY: Codes, 1942, § 5651.5; Laws, 1956, ch. 342, § 1.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 107.

CJS.
44 C.J.S., Insurance § 148.

§ 83-19-9. Powers.

Corporations created under the provisions of this chapter shall have all the powers and privileges enjoyed by corporations created under the general corporation laws of this state, and may issue shares of stock of different classes, within the limits fixed by law, and may fix the relative rights and liability of the holders of each class of stock.

HISTORY: Codes, 1906, § 2591; Hemingway's 1917, § 5055; 1930, § 5157; 1942, § 5667.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 105, 106.

CJS.
44 C.J.S., Insurance §§ 153-156.

§ 83-19-11. Organization of insurance companies.

The procedure for organizing such a corporation shall be as follows: The proposed incorporators, a majority of whom must be residents of the state and not less than three (3), shall subscribe articles of association setting forth their intention to form a corporation; its proposed name, which must be approved by the commissioner and must not so closely resemble the name of an existing corporation doing business under the laws of this state as to be likely to mislead the public; the class or classes of insurance it proposes to transact and on what business plan or principle; the place within the state of its location; and, if on the stock plan, the amount of its capital stock. The words "insurance company" must be a part of the title of any such corporation.

HISTORY: Codes, 1892, § 2333; 1906, § 2578; Hemingway's 1917, § 5042; 1930, § 5146; 1942, § 5656; Laws, 1997, ch. 410, § 12, eff from and after July 1, 1997.

Cross References — Organization of title insurance company, see §§ 83-15-1 et seq.
Certificate of authority of agent or organizer, see § 83-17-5.
For provisions relating to the change of domicile of a domestic or foreign insurer, see §§ 83-20-1 et seq.

JUDICIAL DECISIONS

1. In general.
Stockholder of domestic insurance corporation was entitled to mandamus to compel inspection of books and records of corporations, upon petition alleging that purpose of such request was "in order to ascertain and know how the affairs of the company are conducted and whether or not the capital of which he has contributed a share is being prudently and properly employed, and in order that he may protect the business and interest of said corporation and his interest as such stockholder," unless the executive officers of the corporation plead and prove as an affirmative defense that the stockholder is actuated by bad motives or that the inspection is not desired in order to obtain information germane to his interest as stockholder, but is for speculative purposes or to gratify idle curiosity, or out of spirit of hostility to the welfare of the corporation. Sanders v. Neely, 197 Miss. 66, 19 So. 2d 424, 1944 Miss. LEXIS 276 (Miss. 1944).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 95 et seq.

CJS.
44 C.J.S., Insurance §§ 144 et seq.

§ 83-19-13. Bylaws.

Any such company may adopt bylaws for the conduct of its business not repugnant to law or to its charter, and shall therein provide for the election of a minimum of three (3) directors. The bylaws may provide for the division of its board of directors into two (2), three (3) or four (4) classes and the election thereof at its annual meetings in such manner as that the members of one (1) class only shall retire and their successors be chosen each year. Vacancies in any such class may be filled by election by the board for the unexpired term.

HISTORY: Codes, 1906, § 2573; Hemingway's 1917, § 5038; 1930, § 5142; 1942, § 5652; Laws, 1997, ch. 410, § 13, eff from and after July 1, 1997.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance §§ 95 et seq.	44 C.J.S., Insurance §§ 144 et seq.

§ 83-19-15. Organizational meeting.

The first meeting for the purpose of organization shall be called by a notice signed by one or more of the subscribers to the articles of association, stating the time, place, and purposes of the meeting, a copy whereof shall, seven (7) days at least before the appointed time, be given to each subscriber, or left at his usual place of business or residence, or duly mailed to his post office address. Whoever gives such notice shall make affidavit thereof, which shall include a copy of the notice and be entered upon the records of the corporation. At such first meeting, including any adjournment thereof, an organization shall be effected by the choice of a temporary clerk, who shall be sworn to correctly keep and record the proceedings of the meeting, by the adoption of bylaws, and by the election of directors and such other officers as the bylaws may require; but at such first meeting no person shall be elected director who has not signed the articles of association. The temporary clerk shall record the proceedings until and including the choice and qualification of the secretary. The directors so chosen shall elect a president, secretary, and other officers who, under the bylaws, they are authorized to choose. The offices of president and treasurer shall not be held by the same individual.

HISTORY: Codes, 1906, § 2579; Hemingway's 1917, § 5043; 1930, § 5147; 1942, § 5657; Laws, 1958, ch. 436, § 1; Laws, 1998, ch. 323, § 3, eff from and after July 1, 1998.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance §§ 95 et seq.	44 C.J.S., Insurance §§ 144 et seq.

§ 83-19-16. Commissioner of Insurance to be notified of changes in officers or directors.

Every domestic insurer shall notify the Commissioner of Insurance in writing of any change in the officers or directors of the insurer either before or immediately after such change becomes effective. The notice shall include biographical affidavits on the new officers or directors in the format developed by the commissioner.

HISTORY: Laws, 1999, ch. 313, § 1, eff from and after July 1, 1999.

§ 83-19-17. Repealed.

Repealed by Laws, 1991, ch. 335, § 1, eff from and after July 1, 1991.
§ 83-19-17. [Codes, 1942, § 5657.1; Laws, 1958, ch. 436, § 2]

Editor's Notes — Former § 83-19-17 set forth qualification for the offices of board chairman and president.

§ 83-19-19. Certificate of organization.

The president, secretary, and majority of the directors shall forthwith make, sign, and swear to a certificate setting forth a copy of the articles of association, with the names of the subscribers thereto, the date of the first meeting, and of any adjournment thereof, and shall submit such certificate and the records of the corporation to the insurance commissioner, who shall examine the same and may require such other evidence as he may deem necessary.

HISTORY: Codes, 1906, § 2579; Hemingway's 1917, § 5043; 1930, § 5147; 1942, § 5657; Laws, 1958, ch. 436, § 1.

Cross References — For provisions relating to the change of domicile of a domestic or foreign insurer, see §§ 83-20-1 et seq.

Articles of association of mutual company, see § 83-31-3.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 95.

CJS.
44 C.J.S., Insurance §§ 148, 167.

§ 83-19-21. License fees; deposit into Insurance Department Fund; funding of agency expenses; deposit of monies into State General Fund.

If it appears that the requirements of the law herein have been complied with, the commissioner shall collect a fee of Two Hundred Dollars ($200.00), to be paid into the special fund in the State Treasury designated as the "Insurance Department Fund" and shall certify the fact and his approval of the articles of association, by endorsement thereon. The commissioner shall also collect a fee of Fifty Dollars ($50.00) for any amendment filed thereon and such fee shall be deposited into the "Insurance Department Fund."

From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1906, § 2580; Hemingway's 1917, § 5044; 1930, § 5148; 1942, § 5658; Laws, 1977, ch. 325; Laws, 1988, ch. 526, § 6; Laws, 1991, ch. 352 § 1; Laws, 2016, ch. 459, § 31, eff from and after July 1, 2016.

Editor's Notes — Section 13 of ch. 526, Laws of 1988, provides as follows:

"SECTION 13. The commissioner may, after notice and hearing, issue rules and regulations that he deems necessary to effectuate the purposes of this act or to eliminate devices or plans designed to avoid or render ineffective the provisions of this act. The commissioner may require such information as is reasonably necessary for the enforcement of this act. All rules and regulations adopted and promulgated pursuant to this act shall be subject to the provisions of the Mississippi Administrative Procedures Law as provided in Section 25-43-1 et seq. [now 25-43-1.101 et seq.], Mississippi Code of 1972."

Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Authority to increase or reduce capital stock, see §§ 83-19-61, 83-19-63.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

CJS.
44 C.J.S., Insurance §§ 118-120.

§ 83-19-23. Repealed.

Repealed by Laws, 1997, ch. 410, § 24, eff from and after July 1, 1997.

§ 83-19-23. [Codes, 1906, § 2581; Hemingway's 1917, § 5045; 1930, § 5149; 1942, § 5659]

Editor's Notes — Former § 83-19-23 prescribed the form and filing requirements of certificates of authority.

§ 83-19-25. Repealed.

Repealed by Laws, 1999, ch. 316, § 1, eff from and after July 1, 1999.

§ 83-19-25. [Codes, 1942, § 5657.2; Laws, 1958, ch. 436, § 3]

Editor's Notes — Former § 83-19-25 related to salaries of nonresident officers and employees.

§ 83-19-27. Examination of financial ability, condition, and affairs.

It shall be the duty of the commissioner of insurance of this state to make an examination of the financial ability, condition, and affairs of each domestic insurance company of this state, within twelve (12) months from the date upon which such domestic insurance company commences to do business in this state, and thereafter regular examinations of the financial ability, condition, and affairs of such domestic insurance companies shall be made as herein provided, and is now provided.

HISTORY: Codes, 1942, § 5659.5; Laws, 1956, ch. 331; Laws, 1958, ch. 437, § 1.

Cross References — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-19-29. New companies to file financial statement each quarter for two years.

It shall be the further duty of the Commissioner of Insurance of this state to require each domestic insurance company to file with the Department of Insurance a sworn financial statement of the company each quarter after it commences to do business, for a period of two (2) years. The statement shall be filed on and in accordance with the NAIC Quarterly Statement Blank and Instructions as well as the NAIC Accounting Practices and Procedures Manual. After the expiration of the two-year period, the annual statement otherwise required by statute will be sufficient unless the Commissioner of Insurance deems it advisable to require a more frequent filing of a financial statement.

HISTORY: Codes, 1942, § 5659.7; Laws, 1958, ch. 437, § 2; Laws, 2003, ch. 384, § 1, eff from and after July 1, 2003.

Cross References — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance § 96.

§ 83-19-31. Capital required for various classes of companies.

(1) No corporation so formed shall transact any other business than that specified in its charter and articles of association. Companies so formed must meet the following capital and surplus requirements:

(a) Single-line companies so formed to write a classification listed in paragraphs (a) through (n) in Section 27-15-83, the minimum capital requirement shall be Four Hundred Thousand Dollars ($400,000.00) and the surplus shall be a minimum of Six Hundred Thousand Dollars ($600,000.00).

(b) Multi-line companies so formed to write a combination of the classifications listed in paragraphs (a) through (n) in Section 27-15-83, the minimum capital requirement shall be Six Hundred Thousand Dollars ($600,000.00) and the surplus shall be a minimum of Nine Hundred Thousand Dollars ($900,000.00).

(c) Companies so formed for the purpose of transacting the business of life insurance on the industrial plan may organize with a minimum capital of One Hundred Thousand Dollars ($100,000.00) and a minimum surplus of Fifty Thousand Dollars ($50,000.00).

An industrial life insurer shall be limited to the following:

(i) A life insurance policy, in the aggregate value of Ten Thousand Dollars ($10,000.00) in death benefits, exclusive of multiple indemnity benefits.

(ii) A disability policy in the aggregate benefits of Sixty Dollars ($60.00) per week.

(iii) A policy providing benefits for dismembered and broken limbs and/or loss of eyesight in the aggregate of Five Thousand Dollars ($5,000.00) per policy year.

(iv) A policy which provides benefits for the payment for or furnishing of hospitalization, drugs, attending physicians and surgical costs in the aggregate of Three Thousand Five Hundred Dollars ($3,500.00) per policy year.

(d) All mutual and reciprocal companies shall possess at the time of initial license and maintain thereafter a surplus, after deductions for services, in an amount equal to the capital and surplus requirements of a stock company writing similar lines of insurance.

(e) If at any time the surplus of such domestic company or association shall be less than the minimum surplus noted above, such company or association shall be considered impaired; and it shall be the duty of the officers of such company or association to report any such impairment of surplus to the State Commissioner of Insurance in writing within ten (10) days after such impairment occurs. When any such impairment is reported, or if the Commissioner of Insurance should determine that the company is operating in an impaired condition, the commissioner may suspend the certificate of authority and license of such domestic insurance company or association to do business in this state until such company shall raise or increase its surplus to the minimum amount required herein.

(2) Any domestic company qualifying under the foregoing sections shall deposit with the State Treasurer fifty percent (50%) of its capital stock, either in cash or in such bonds or securities in which such company is authorized by law to invest its funds. Upon such deposit and evidence, by affidavit or otherwise, satisfactory to the Insurance Commissioner that the capital and surplus is all paid in and that the company is the actual and unqualified owner of the securities representing the paid-up capital and surplus, he shall issue to such company his certificate authorizing it to transact business in this state.

The provisions of this section as to the minimum requirements as to paid-up capital stock and cash surplus shall not become effective until January

1, 1988, concerning any domestic company which was authorized to do business and was writing business in this state on July 1, 1985.

Notwithstanding any other provision of law, the securities qualified for deposit under this section may be deposited with a clearing corporation or held in the Federal Reserve book-entry system. Securities deposited with a clearing corporation or held in the Federal Reserve book-entry system and used to meet the deposit requirements set forth in this section shall be under the control of the Insurance Commissioner and shall not be withdrawn by the insurance company without the approval of the Insurance Commissioner. Any insurance company holding securities in such manner shall provide to the Insurance Commissioner evidence issued by its custodian or member bank through which such insurance company has deposited such securities in a clearing corporation or through which such securities are held in the Federal Reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian or other direct participant or member bank, and that the records of the custodian, other participant or member bank reflect that such securities are held subject to the order of the Insurance Commissioner.

(3) No insurance company, including any mutual insurance company, organized under the laws of this state and transacting business in this state shall expose itself to loss on any one (1) risk or hazard to an amount exceeding ten percent (10%) of its paid-up capital and surplus unless the excess is reinsured in some other company duly authorized to transact similar business in this state or as otherwise provided in the insurance code. For purposes of this subsection, the terms “risk” and “hazard” apply to the subject matter of any one (1) insurance policy and not to any one (1) peril.

(4) The Commissioner of Insurance may require additional capital and surplus based on the type, nature or volume of business transacted.

HISTORY: Codes, 1892, § 2334; 1906, § 2582; Hemingway’s 1917, § 5046; 1930, § 5150; 1942, § 5660; Laws, 1956, ch. 336, § 1; Laws, 1958, ch. 449; Laws, 1960, ch. 368; Laws, 1962, ch. 455, § 1; Laws, 1972, ch. 445, § 1, 1976, ch. 402, § 1; Laws, 1982, chs. 404, § 1; 500, § 1; Laws, 1985, ch. 401; Laws, 1989, ch. 442, § 1; Laws, 1992, ch. 425, § 1; Laws, 1998, ch. 323, § 4; Laws, 1999, ch. 475, § 2; Laws, 2001, ch. 412, § 5; Laws, 2015, ch. 316, § 1, eff from and after July 1, 2015.

Cross References — Factors to be considered in determining reasonableness of surplus of companies writing casualty, ordinary life or health and accident insurance, see § 83-6-23.

Capital required for title insurance company, see § 83-15-5.

Purposes for the organization of insurance companies, see § 83-19-1.

Transaction of business upon increased or reduced capital, see § 83-19-59.

Utilization of modern systems such as clearing corporations and the Federal Reserve book-entry system for the deposit of securities without physical delivery, see §§ 83-67-1 et seq.

JUDICIAL DECISIONS

1. In general.

Section 97-1-1, in conjunction with § 83-19-31 and [former] § 83-19-73, is not void for vagueness due to the lack of written accounting procedures to be used to determine the minimum capital and surplus requirements of an insurance company. Gardner v. State, 531 So. 2d 805, 1988 Miss. LEXIS 481 (Miss. 1988).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 72.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 20 (petition for mandamus to compel issuance certificate of authority where company complied with capitalization requirement established by statute).

CJS.

44 C.J.S., Insurance §§ 121-123.

§ 83-19-33. Capital stock payment.

The capital stock shall be paid in cash within twelve (12) months from the date of charter or certificate of organization, unless the commissioner of insurance on proper showing shall grant additional time for the completion of the sale and payment of said stock; and no certificate of full shares shall be issued until paid for in full. No policies shall be issued until an amount equal to the minimum required by law shall have been paid into the company and a license to engage in business has been issued by the commissioner of insurance.

HISTORY: Codes, 1906, § 2583; Hemingway's 1917, § 5047; 1930, § 5151; 1942, § 5661; Laws, 1924, ch. 192; Laws, 1958, ch. 438, § 1.

Cross References — Certificate of authority to issue policies, see § 83-19-5.

JUDICIAL DECISIONS

1. In general.

Fact that one is stockholder in fire company does not affect his right to recover on policy. Mississippi Fire Ass'n v. Stein, 88 Miss. 499, 41 So. 66, 1906 Miss. LEXIS 168 (Miss. 1906).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 108.

CJS.

44 C.J.S., Insurance § 149.

§ 83-19-35. Commissioner to approve the price per share of stock.

The commissioner of insurance shall approve the price per share of stock to be issued by a domestic insurance company upon the filing of a prospectus or brochure by the company. Said prospectus or brochure shall show the total number of shares authorized, and the number of shares to be issued at a specified price, and shall contain in large print the wording "This stock is purely speculative." The above provisions shall also apply to any stock subscribed to under escrow agreement at any organizational meeting.

HISTORY: Codes, 1942, § 5661-01; Laws, 1958, ch. 438, § 2, eff from and after passage (approved May 6, 1958).

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 108.	44 C.J.S., Insurance § 149.

§ 83-19-37. Stock sale.

No stock sale shall be approved at a par value of less than One Dollar ($1.00) per share, and no stock sale shall be approved in which commissions paid to salesmen, agents, or brokers exceed ten percent (10%) of the asking price of the stock.

HISTORY: Codes, 1942, § 5661-02; Laws, 1958, ch. 438, § 3, eff from and after passage (approved May 6, 1958).

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance §§ 76, 108.	44 C.J.S., Insurance §§ 138, 149.

§ 83-19-39. Escrow deposits.

The par value of each share and fifty percent (50%) of the amount allocated to surplus shall be deposited in escrow in a bank in the State of Mississippi, jointly payable to the commissioner of insurance and the company, which deposit shall remain in escrow until sufficient funds are raised to permit the licensing of the company, or returned to the stockholders in lieu of such licensing.

HISTORY: Codes, 1942, § 5661-03; Laws, 1958, ch. 438, § 4, eff from and after passage (approved May 6, 1958).

RESEARCH REFERENCES

Am. Jur.
28 Am. Jur. 2d, Escrow §§ 1, 2 et seq.

§ 83-19-41. No stock to be placed on option.

The commissioner of insurance shall examine the charter and bylaws of each company applying for license to do business under the domestic insurance company laws to determine that no stock is placed on option. It shall be unlawful for any domestic insurance company to declare a stock dividend within five (5) years from date of incorporation.

HISTORY: Codes, 1942, § 5661-04; Laws, 1958, ch. 438, § 5, eff from and after passage (approved May 6, 1958).

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 108.	44 C.J.S., Insurance § 149.

§ 83-19-43. Qualification of certain stock sales with securities exchange commission.

Any insurance company formed under the laws of the State of Mississippi, whose organizers or incorporators consist of one or more nonresidents of the State of Mississippi, shall, in addition to having the approval of the commissioner of insurance of all stock sales, likewise qualify the sale of stock in such company with the securities exchange commission.

HISTORY: Codes, 1942, § 5661-05; Laws, 1958, ch. 438, § 6, eff from and after passage (approved May 6, 1958).

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 108.	44 C.J.S., Insurance § 149.

§ 83-19-45. Organization through sale of stock in holding company prohibited.

No insurance company shall be organized through the sale of stock in a holding or investment company.

HISTORY: Codes, 1942, § 5661-06; Laws, 1958, ch. 438, § 7, eff from and after passage (approved May 6, 1958).

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 108.	44 C.J.S., Insurance § 149.

§ 83-19-47. Violation to invalidate organization of company.

Any violation of the provisions in Sections 83-19-33 through 83-19-45 shall invalidate the organization of any proposed domestic insurance company, either prior to or following its licensing by the insurance department.

HISTORY: Codes, 1942, § 5661-07; Laws, 1958, ch. 438, § 8, eff from and after passage (approved May 6, 1958).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

§ 83-19-49. License fees.

The licensing fees applicable to domestic insurance companies and stock salesmen shall be as provided in Section 83-5-19, Mississippi Code of 1972.

HISTORY: Codes, 1942, § 5661-08; Laws, 1958, ch. 438, § 9, eff from and after passage (approved May 6, 1958).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

CJS.
44 C.J.S., Insurance §§ 118-120, 131, 132.

§ 83-19-51. Investment of funds by domestic insurance companies.

(1) A domestic insurance company may invest its capital, surplus, and other funds, or certain parts thereof, in the following:

(a) Bonds or other evidence of indebtedness of the United States, of any state of the United States, of the Dominion of Canada, or of any province thereof.

(b) Bonds or other evidence of indebtedness of any county, city, town, village, school district, municipal district, or other civil district within the United States or the Dominion of Canada.

(c) Bonds or notes secured by mortgages or deeds of trust upon unencumbered real estate in the United States or Dominion of Canada worth at least thirty-three and one-third percent (33-⅓%) more than the amount loaned thereon, and may also loan upon the security of improved unencumbered real property in any state, provided the security be eligible for insurance and be insured under provisions of the National Housing Act and any amendments thereto. Where improvements on the land constitute a part of the value on which the loan is made, the improvements shall be insured against fire and tornado for the benefit of the mortgagee, in an amount not less than the difference between seventy-five percent (75%) of the value of the land and the amount of the loan. For the purposes of this paragraph (c), real estate shall not be deemed to be encumbered within the meaning of this section by reason of the existence of taxes or assessments that are not delinquent, instruments creating or reserving mineral, oil, or timber rights, rights-of-way, joint driveways, sewer rights, rights in walls, or other comparable or similar instruments, rights, restrictions, and covenants, nor by reason of building restrictions or restrictive covenants, nor when such real estate is subject to lease in whole or in part whereby rents or profits are reserved to the owner, provided such lease and the notes for rent given thereunder be assigned by the lessor to the company.

(d) Bonds, notes, or other evidences of indebtedness which are secured by mortgages, security deeds, vendor's liens, or deeds of trust upon leasehold estates having an unexpired term of twenty-five (25) years or longer in improved unencumbered real estate in the United States worth at least thirty-three and one-third percent (33-⅓%) more than the amount loaned thereon. For the purposes of this paragraph (d), the real estate on which such leasehold estate exists shall not be deemed to be encumbered within the meaning of this section by reason of the existence of taxes or assessments that are not delinquent, instruments creating or reserving mineral, oil, or timber rights, rights-of-way, joint driveways, sewer rights, rights in walls, or other comparable or similar instruments, rights, restrictions, and covenants, nor by reason of building restrictions or restrictive covenants.

(e) In bankers' acceptances and bills of exchange of the kinds and maturities made eligible by law for rediscount with Federal Reserve banks, provided that the same are accepted by a bank or trust company incorporated under the laws of the United States, of this commonwealth, or by any other bank or trust company which is a member of the Federal Reserve system. However, not more than ten percent (10%) of the admitted assets shall be so invested.

(f) Stock in Federal Home Loan Bank, or bonds, debentures, notes, or other evidences of indebtedness, or the preferred or guaranteed stock or shares of any solvent institution created or existing under the laws of the United States, or any state thereof. No life insurance company shall invest in its own stock and may not invest more than ten percent (10%) of its total assets in the preferred or guaranteed stock or bonds of any one (1) corporation, as above described.

(g) Bonds, debentures, notes or other evidences of indebtedness, or the preferred or guaranteed stock or shares issued by or guaranteed by any solvent institution domiciled outside the United States or created under the laws of a nation other than the United States; however, no insurance company shall invest more than twenty percent (20%) of its total assets in foreign investments as described herein. No life insurance company shall invest more than ten percent (10%) of its total assets in the evidences of indebtedness of any one (1) corporation, as above described. After notice and hearing, and for good cause shown, the commissioner shall have the authority to disallow any investment by a domestic insurance company in any institution located in a foreign nation.

(h) Loans upon the pledge of any of the securities herein authorized.

(i) In adequately secured equipment trust certificates or other adequately secured instruments evidencing an interest in equipment wholly or partly within the United States, and a right to receive determined portions or rental, purchase or other fixed obligatory payments for the use or purchase of such equipment, provided that not more than five percent (5%) of its total assets be so invested.

(j) The common capital stock of any bank or trust company which is a member of the Federal Deposit Insurance Corporation and has earned no less than five percent (5%) on its total capital accounts for each of the preceding three (3) years, not to exceed, however, ten percent (10%) of the actually issued and outstanding common capital stock of any one (1) such bank or trust company; or a building and loan association which is a member of the Federal Savings and Loan Insurance Association and has earned no less than five percent (5%) on its total capital accounts for each of the preceding three (3) years, not to exceed, however, ten percent (10%) of the actually issued and outstanding common capital stock of any one (1) such building and loan association; provided that not more than five percent (5%) of the assets of such domestic company shall be so invested at any time in common stock of either banks or trust companies, or building and loan associations, or in an aggregate of the two (2).

Provided, however, no domestic insurance company may acquire common stock in any bank or building and loan association in this state when such acquisition will cause the aggregate of such stock held by any domestic insurance company or companies to exceed fifteen percent (15%) of the common stock of such bank or building and loan association.

(k) A life insurance company may also purchase for its own benefit any policy of life insurance or other obligation of the company and claims of the holders thereof, and may lend to the holders of its life insurance policies sums not exceeding in any case the reserve value of the policy at the time the loan is made and, for the payment of any such loan, the policy and all profits thereon shall be pledged.

(*l*) A company doing business in a foreign country may invest the funds required to meet its obligations in such country and, in conformity to the laws thereof, in the same kinds of securities in such foreign country that such company is allowed by law to invest in the United States.

(m) Bonds or other evidences of indebtedness of the Inter-American Development Bank.

(n) Cash or deposits in checking or savings accounts, under certificates of deposit or in any other form, or other certificates or evidence of indebtedness from solvent banks and trust companies and in savings accounts, certificates of deposit or similar certificates or evidences of deposits in solvent savings and loan associations and building and loan associations.

(o) Construction loans, repurchase agreement transactions, standby mortgage loan commitments, electronic, computer or data processing equipment investments, financial risk limiting and balancing transactions, including put and call options purchased solely for legitimate financial futures hedging, nonspeculative purposes if these transactions are traded upon a contract market designated and regulated by a federal agency.

(p) Bonds or other evidences of indebtedness of the African Development Bank.

(q) Any other investment expressly authorized by law.

(2) Any domestic company may invest an amount not to exceed ten percent (10%) of its total admitted assets and to further increase such authority by an additional four percent (4%) provided such four percent (4%) investments are made in the State of Mississippi without regard to the limitations of any other subsection of this section or of any other act or acts regulating or governing the investments of domestic companies.

(3) Any domestic company may invest an amount not to exceed ten percent (10%) of its admitted assets in common shares of solvent corporations incorporated under the laws of any of the states among the United States of America or created under the laws of a nation other than the United States without regard to the restrictions in, and notwithstanding the provisions of, any other subsection of this section or of any other act or acts regulating or governing the investments of domestic companies. No life insurance company shall invest more than five percent (5%) of its admitted assets in common shares of any one (1) corporation as hereinbefore provided. After notice and hearing, and for good cause shown, the commissioner shall have the authority to disallow any investment by a domestic insurance company in any institution located in a foreign nation.

Conflict of interest. Provided, however, no domestic insurance company shall under this section acquire common stock in any company where the officers or directors of the insurance company, individually or collectively, hold an interest in excess of ten percent (10%) of the company in which the common stock is acquired. For the purpose of this limitation, interest is defined as actual ownership, ownership in the name of a trustee, ownership in the name of a relative within the third degree, ownership in the name of an owned or controlled corporation or business, or ownership in the form of an option.

Provided further, no officer or director of the insurance company shall either directly or indirectly derive any profit or revenue from stock purchases under the above subsection, either in the form of commissions, brokerage, or the outright sale of shares of stock to the insurance company.

(4) No amount at any time shall be loaned from any funds or investments described herein to any stockholder, officer or director of the company; provided, however, this subsection shall not prohibit any person from obtaining a loan or exercising other contractual rights pursuant to the provisions of a policy or contract for insurance to which the person is a party or otherwise has the legal right to exercise such contractual rights.

(5) Notwithstanding the provisions of this section, the commissioner may, after notice and hearing, order a company to limit or withdraw from certain investments, or discontinue certain investment practices, to the extent that the commissioner finds that such investments or investment practices endanger the solvency of the company.

(6) No loan or investment, except loans on the security of life insurance policies, shall be made by any such company unless the same shall have been authorized by the board of directors or by a committee thereof charged with the duty of supervising loans or investments, and no company shall enter into any

agreement to withhold from sale any of its securities or property; but the disposition of its assets shall at all times be within the control of the company.

Nothing in this law shall prohibit a company from accepting in good faith, to protect its interest, securities or property other than herein referred to, in payment of or to secure debts due or to become due the company.

(7) Nothing in this section shall be construed as affecting any investment existing on April 27, 1966; and this section shall not repeal Sections 43-33-301 through 43-33-307 of the Mississippi Code of 1972.

HISTORY: Codes, 1906, § 2583; Hemingway's 1917, § 5047; 1930, § 5152; 1942, § 5662; Laws, 1924, ch. 192; Laws, 1940, ch. 206; Laws, 1954, ch. 309, §§ 1-3; Laws, 1958, ch. 439; Laws, 1962, ch. 457, §§ 1-6; ch. 458; Laws, 1964, ch. 470, §§ 1-6; Laws, 1966, ch. 522, §§ 1-5. 1984, ch. 329; Laws, 1985, ch. 483; Laws, 1988, ch. 370; Laws, 1992, ch. 340, § 1; Laws, 1997, ch. 325, § 1; Laws, 1999, ch. 475, § 1; Laws, 2003, ch. 414, § 1; Laws, 2010, ch. 451, § 1, eff from and after passage (approved Mar. 31, 2010).

Cross References — Bonds of county or regional railroad authorities as legal investments, see § 19-29-37.

Provisions on insured loans, see §§ 43-33-101 et seq.

Authority to invest in evidences of indebtedness insured by Federal Housing Administrator and others, see § 43-33-303.

Authority to invest in bonds issued by approval of Agricultural and Industrial Board, see § 57-3-31.

Investments in county industrial development authority bonds, see § 57-31-27.

Notes issued by municipalities to finance industrial enterprise projects as legal investments for insurance companies, see § 57-41-11.

Authority to invest in bonds issued under State Ports and Harbors Law, see § 59-5-63.

Authority to invest in farm credit securities, see § 75-69-7.

Stock of subsidiary corporation of insurer not to be valued at amount in excess of net value based upon assets eligible under this section, see § 83-5-117.

Investments by domestic insurers in securities of subsidiaries not subject to restrictions in this section, see § 83-6-2.

Reserve liabilities of life insurance companies, see §§ 83-7-21 et seq.

Commissioner's power to act as receiver, see § 83-23-1.

Powers and duties of commissioner in effectuating insurance guaranty laws, see §§ 83-23-119, 83-23-221.

Investment of funds by fraternal societies, see § 83-29-17.

Investment of funds of nonprofit dental service corporations, see § 83-43-23.

Authority to invest in obligations of Tennessee Valley Authority, see § 91-13-11.

Federal Aspects — Federal Home Loan Banks, see 12 USCS §§ 1421 et seq. National Housing Act, see 12 USCS §§ 1701 et seq.

JUDICIAL DECISIONS

1. In general.

Interest-bearing securities and solvent credits acquired by domestic insurance corporation in making loans held exempt from ad valorem taxes. Miller v. Lamar Life Ins. Co., 158 Miss. 753, 131 So. 282, 1930 Miss. LEXIS 117 (Miss. 1930).

Mortgagee relying on waiver of first lien by president of insurance company could presume that action of president was act of corporation. McDowell v. Federal Land Bank, 156 Miss. 820, 127 So. 288, 1930 Miss. LEXIS 227 (Miss. 1930).

Neither receiver nor corporation could

avail of ultra vires act of president in executing waiver of first lien. McDowell v. Federal Land Bank, 156 Miss. 820, 127 So. 288, 1930 Miss. LEXIS 227 (Miss. 1930).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 105, 106.

CJS.
44 C.J.S., Insurance §§ 154-156.

§ 83-19-53. Investment to finance buildings for General Services Administration.

A domestic insurance company may invest its funds in financing the construction of public buildings and improvements for the use of the United States of America through the General Services Administration pursuant to the provisions of Title I, Public Law 519, 83rd Congress, known as the Public Buildings Purchase Contract Act of 1954 (68 Stat. 518), as amended by Public Law 150, 84th Congress (69 Stat. 297), and Public Law 667, 84th Congress (70 Stat. 510), which amends the Public Buildings Act of 1949, Public Law 105, 81st Congress, approved June 16, 1949 (63 Stat. 176), and all laws amendatory thereof or supplemental thereto; and to that end may acquire, hold and convey real estate and other property and make and enter into any and all contracts and agreements deemed necessary or advisable by it to carry out the purposes of this section and protect the interests of such company; provided, however, that repayment of the loans and advances for such construction, with interest thereon, shall be obligations of or guaranteed by the United States of America.

This section is cumulative to and shall not repeal any other statutes of this state dealing with the investment of funds or the acquisition, holding, and conveyance of property by a domestic insurance company.

HISTORY: Codes, 1942, § 5662.5; Laws, 1958, ch. 451, §§ 1, 2.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 105, 106.

CJS.
44 C.J.S., Insurance §§ 154-156.

§ 83-19-55. Real estate holdings.

A domestic company may acquire, hold, and convey real estate for the purposes and in the manner only following:

(a) The buildings in which it has its principal office and the land on which it stands.

(b) Such as shall be requisite for its convenient accommodation in the transaction, enlargement, and advancement of its business.

(c) Such as shall have been acquired for the accommodation of its business.

(d) Such real estate as it may purchase or hold for the production of income. It may improve or otherwise develop in any manner such real estate and the improvements thereon, and may own, maintain, manage, collect and receive income from, and sell or convey the same. Said real estate described in paragraphs (a), (b), (c) and (d) shall not exceed in value, as evidenced by its original purchase price including any encumbrances thereon, fifteen percent (15%) of the assets of such company, unless the company file with the commissioner application for permission to exceed said proportion, stating its reasons therefor, and obtain his certificate approving the same.

(e) Such as shall have been mortgaged to it in good faith, by way of security for loans previously contracted for money due.

(f) Such as shall have been conveyed to it in satisfaction of debts previously contracted in the course of its dealings.

(g) Such as it shall have purchased at sales on judgments, decrees or mortgages obtained or made for debts.

All real estate specified in paragraphs (c), (e), (f) and (g) of this section shall be sold by the company and disposed of within five (5) years after it shall have acquired the title to the same, unless the company obtain the certificate of the commissioner that its interests will suffer materially from a forced sale thereof, in which event the time for the sale may be extended to such time as the commissioner shall direct in such certificate. The company may, however, elect to consider property acquired as specified in paragraphs (c), (e), (f) and (g) as real estate for the production of income, as defined in paragraph (d). Such election shall be evidenced by a written notice thereof to the commissioner, and, where such election is made, property so acquired shall be subject to the limitation of fifteen percent (15%) of the company's assets, as defined in paragraph (d), and shall not be required to be sold within said five-year period.

HISTORY: Codes, 1892, § 2331; 1906, § 2574; Hemingway's 1917, § 5039; 1930, § 5143; 1942, § 5653; Laws, 1946, ch. 362, § 1.

Cross References — Purchase of public lands, see § 29-1-75.
Real estate holdings of banks, see § 81-5-87.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 105, 106.

CJS.
44 C.J.S., Insurance §§ 154-156.

§ 83-19-57. Capital impairment.

When the net assets of a company do not amount to more than three-fourths (¾) of its original paid-up capital, it may make good its capital to the original amount by assessment of its stock, and shall not write any new business until same is made good or reduced to minimum amount required by this chapter. If such company shall not, within three (3) months after notice from the commissioner to that effect, make good its capital as aforesaid or reduce the same, its authority to transact new business of insurance will be revoked by said commissioner.

HISTORY: Codes, 1906, § 2584; Hemingway's 1917, § 5048; 1930, § 5153; 1942, § 5663.

Cross References — Suspension or revocation of certificate of authority for unsound condition, see § 83-1-29.

Revocation of license for unsound condition, see § 83-5-17.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 108.	44 C.J.S., Insurance § 149.

§ 83-19-59. Application to increase or reduce capital stock.

The commissioner shall, upon application, examine the proceedings of domestic companies to increase or reduce their capital stock and, when found conformable to law shall indorse certificates thereof and shall issue certificates of authority to such company to transact business upon such increased or reduced capital. He shall not allow stockholders' obligations of any description as part of the assets or capital of any insurance company unless the same are secured by competent collateral.

HISTORY: Codes, 1880, § 1087; 1892, § 2338; 1906, § 2568; Hemingway's 1917, § 5033; 1930, § 5140; 1942, § 5650.

Cross References — Capital required for various classes of companies, see § 83-19-31.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 108.	44 C.J.S., Insurance § 149.

§ 83-19-61. Increase of capital stock.

Any such company having a paid-up capital, as required by law, may increase its capital stock by a vote of its stockholders, and issue certificates for the additional shares, which may be paid for in cash or in such installments as the company may determine. Such certificates shall show on their face the amount actually paid (unless paid in full), and no capital shall be advertised except the amount actually paid. The company shall, within thirty (30) days after authorizing such increase of capital, report the fact to the commissioner, setting forth the amount of such increase and the amount of same to be paid in cash. If the commissioner finds that the facts conform to the law, he shall indorse his approval thereon; and upon filing such certificate so indorsed with the secretary of state and paying a fee of Five Dollars ($5.00) for filing and recording the same, the company may continue to dispose of such authorized increase as has not been disposed of, and to transact business upon the capital as thus increased. As soon as the whole of such authorized increase has been placed or disposed of, the company shall report the fact to the commissioner;

and if not disposed of in six (6) months from the date of the first report herein required, a report shall then be made of the transactions to that date.

HISTORY: Codes, 1906, § 2585; Hemingway's 1917, § 5049; 1930, § 5154; 1942, § 5664.

Cross References — Penalty for publishing amount of capital not paid in cash, see § 83-5-9.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 108.	44 C.J.S., Insurance § 149.

§ 83-19-63. Reduction of capital stock.

When the capital stock of a company is impaired, such company may, upon a vote of the majority of the stock represented at a meeting called for that purpose, reduce its capital stock and the number of shares thereof to an amount not less than the minimum sum required by law. No part of its assets and property shall be distributed to its stockholders, but shall remain as surplus fund. Within ten (10) days after such meeting, the company shall submit to the commissioner a certificate setting forth the proceedings thereof, the amount of such reduction, and the assets and liabilities of the company, signed and sworn to by its president, secretary, and a majority of its directors. The commissioner shall examine the facts in the case and, if the same conform to law and in his judgment the proposed reduction may be made without prejudice to the public, he shall indorse his approval upon the certificate. Upon filing the certificate so indorsed in the office of the secretary of state and paying a fee of Five Dollars ($5.00) for the filing and recording thereof, the company may transact business upon the basis of such reduced capital as though the same were its original capital. Its charter shall be deemed to be amended to conform thereto, and the secretary of state shall issue his certificate to that effect. Such company may, by a majority vote of its directors after such reduction, require the return of the original certificates of stock held by each stockholder in exchange for new certificates it may issue in lieu thereof for such number of shares as each stockholder is entitled to in the proportion that the reduced capital bears to the original.

HISTORY: Codes, 1906, § 2586; Hemingway's 1917, § 5050; 1930, § 5155; 1942, § 5665.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 108.	44 C.J.S., Insurance § 149.

§ 83-19-65. Dividends.

No stock company shall make a dividend, either in cash or stock certificates, except from its actual net surplus computed as required by law in its annual statements. Nor shall any company which has ceased to do new business of insurance divide any portion of its assets, except surplus, to its stockholders until it shall have performed or cancelled its policy obligations.

HISTORY: Codes, 1892, § 2335; 1906, § 2587; Hemingway's 1917, § 5051; 1930, § 5156; 1942, § 5666.

Cross References — Restrictions on payment of extraordinary dividends by registered insurers, see § 83-6-25.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 114.

CJS.
44 C.J.S., Insurance §§ 162-165.

§ 83-19-67. Regulation of management contracts.

Any management contract between a domestic insurer and another person, as defined in Section 83-6-1(f), shall be filed and subject to review and final approval of the State Insurance Department.

HISTORY: Codes, 1942, § 5657.3; Laws, 1958, ch. 436, § 4; Laws, 1999, ch. 314, § 1, eff from and after July 1, 1999.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-19-69. Certain contracts prohibited in another state.

Subject to the exceptions set forth herein, no domestic insurer shall enter into a contract of insurance upon the life or person of a resident of any other state, or covering property or risks located in any other state, unless such insurer is authorized pursuant to the laws of such other state to do business therein.

The following constitute the exceptions to the foregoing provisions of this section:

(a) Life insurance contracts entered into where the prospective insurant is personally present in a state in which the insurer is authorized to do business when he signs the application.

(b) Issuance of certificates under any lawfully transacted group life, group accident, group health, or other group disability policy, where the master policy is entered into in a state in which the insurer is authorized to do business.

(c) Contracts made pursuant to a pension or retirement plan of an employer, when such contracts are applied for in a state where the employer is personally present or doing business and the insurer is authorized to do business.

(d) The renewal, reinstatement, conversion, or continuance in force with or without modification of contracts otherwise lawfully entered into and which were not originally executed in violation of this section, where the terms of such policy as originally executed leave no option as to renewal, reinstatement, or continuance in force to the insurer, but vest such rights in the insured alone.

(e) Reinsurance contracts entered into upon request from companies in other states covering risks in other states, provided such companies requesting reinsurance are licensed in the states in which the risks are located.

Any company wilfully violating this section shall be subject to suspension of its license to do business in this state for a period of not more than one (1) year, after ten (10) days' notice in writing and hearing by the commissioner of insurance.

HISTORY: Codes, 1942, § 5670.5; Laws, 1964, ch. 475, §§ 1, 2, eff from and after passage (approved June 11, 1964).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 65.

§ 83-19-71. Repealed.

Repealed by Laws, 1991, ch. 501, § 6, eff from and after July 1, 1991.

§ 83-19-71. [Codes, 1930, § 5158; 1942, § 5668; Laws, 1926, ch. 262; Laws, 1930, ch. 211; Laws, 1940, ch. 205; Laws, 1952, ch. 298; Laws, 1958, ch. 440; Laws, 1962, ch. 459]

Editor's Notes — For current provisions applicable to reinsurance, see §§ 83-19-151 et seq.

§ 83-19-73. Repealed.

Repealed by Laws, 1998, ch. 323, § 9, eff from and after July 1, 1998.

§ 83-19-73. [Codes, 1942, § 5670.1; Laws, 1958, ch. 452, § 1; Laws, 1962, ch. 461, §§ 1-3; Laws, 1976, ch. 402, § 2; Laws, 1987, ch. 365; Laws, 1997, ch. 410, § 15, eff from and after July 1, 1997]

Editor's Notes — Former Section 83-19-73 provided a schedule of minimum capital surplus requirements to be maintained by domestic stock, insurance companies and associations doing business in Mississippi. See now § 83-19-31.

§ 83-19-75. Penalty for failure to report impairment of surplus.

If the surplus of any domestic insurance company or association shall be impaired, as provided in Sections 83-19-75 and 83-19-77, and such impairment shall not be reported to the Commissioner of Insurance of this state within ten (10) days after such impairment occurs or results, the executive officers, secretary, treasurer, and directors of such company shall each be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not more than Five Hundred Dollars ($500.00) or by imprisonment in the county jail for not more than six (6) months, or by both such fine and imprisonment, in the discretion of the court.

HISTORY: Codes, 1942, § 5670.2; Laws, 1958, ch. 452, § 2; Laws, 2001, ch. 379, § 2, eff from and after July 1, 2001.

Cross References — Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 69.

CJS.
44 C.J.S., Insurance § 139.

§ 83-19-77. Exceptions to surplus requirements.

Sections 83-19-75 and 83-19-77 shall not be construed as applicable to fraternal, benevolent, or burial associations, or any other organization not specifically named in the foregoing schedule.

HISTORY: Codes, 1942, § 5670.4; Laws, 1958, ch. 452, § 4; Laws, 2001, ch. 379, § 3, eff from and after July 1, 2001.

Cross References — Regulation of fraternal societies, see §§ 83-29-1 et seq.
Regulation of burial associations, see §§ 83-37-1 et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 142, 143 et seq.

CJS.
44 C.J.S., Insurance §§ 162-165, 176.

§ 83-19-79. "Equity security" defined.

The term "equity security" when used in Sections 83-19-79 through 83-19-97 means any stock or similar security; or any security convertible, with or without consideration, into such a security, or carrying any warrant or right to subscribe to or purchase such a security; or any such warrant or right; or any other security which the commissioner of insurance shall deem to be of similar nature and consider necessary or appropriate, by such rules and regulations as he may prescribe in the public interest or for the protection of investors, to treat as an equity security.

HISTORY: Codes, 1942, § 5670.7-08; Laws, 1966, ch. 528, § 8, eff from and after passage (approved March 17, 1966).

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 108.	44 C.J.S., Insurance § 149.

§ 83-19-81. Statements of ownership of equity securities.

Every person who is directly or indirectly the beneficial owner of more than ten percent (10%) of any class of any equity security of a domestic stock insurance company, or who is a director or an officer of such company, shall file in the office of the commissioner of insurance within ten (10) days after he becomes such beneficial owner, director, or officer, a statement in such form as the commissioner of insurance may prescribe of the amount of all equity securities of such company of which he is the beneficial owner; and within ten (10) days after the close of each calendar month thereafter, if there has been a change in such ownership during such month, shall file in the office of the commissioner of insurance a statement in such form as the commissioner of insurance may prescribe, indicating his ownership at the close of the calendar month and such changes in his ownership as have occurred during such calendar month.

HISTORY: Codes, 1942, § 5670.7-01; Laws, 1966, ch. 528, § 1, eff from and after passage (approved March 17, 1966).

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 109.	44 C.J.S., Insurance § 152.

§ 83-19-83. Recovery of profit realized from certain purchase or sale of equity security.

For the purpose of preventing the unfair use of information which may have been obtained by such beneficial owner, director, or officer by reason of his relationship to such company, any profit realized by him from any purchase and sale, or any sale and purchase, of any equity security of such company within any period of less than six (6) months, unless such security was acquired in good faith in connection with a debt previously contracted, shall inure to and be recoverable by the company, irrespective of any intention on the part of such beneficial owner, director, or officer in entering into such transaction of holding the security purchased or of not repurchasing the security sold for a period exceeding six (6) months. Suit to recover such profit may be instituted at law or in equity in any court of competent jurisdiction by the company, or by the owner of any security of the company in the name and in behalf of the company, if the company shall fail or refuse to bring such suit within sixty (60) days after request or shall fail diligently to prosecute the same thereafter; but no such suit shall be brought more than two (2) years after the date such profit was realized. This section shall not be construed to cover any transaction where such beneficial owner was not beneficial owner both at the time of the purchase and sale, or the sale and purchase, of the security involved, or any transaction or transactions which the commissioner of insurance by rules and regulations may exempt as not comprehended within the purpose of this section.

HISTORY: Codes, 1942, § 5670.7-02; Laws, 1966, ch. 528, § 2, eff from and after passage (approved March 17, 1966).

Cross References — Certain purchases and sales excepted from application of provisions of this section, see § 83-19-87.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 109.	44 C.J.S., Insurance § 152.

§ 83-19-85. Prohibition of certain sales of equity security.

It shall be unlawful for any such beneficial owner, director, or officer, directly or indirectly, to sell any equity security of such company if the person selling the security or his principal (i) does not own the security sold, or (ii) if owning the security, does not deliver it against such sale within twenty (20) days thereafter, or does not within five (5) days after such sale deposit it in the mails or other usual channels of transportation. No person shall be deemed to have violated this section if he proves that, notwithstanding the exercise of good faith, he was unable to make such delivery or deposit within such time, or that to do so would cause undue inconvenience or expense.

HISTORY: Codes, 1942, § 5670.7-03; Laws, 1966, ch. 528, § 3, eff from and after passage (approved March 17, 1966).

Cross References — Certain sales excepted from application of provisions of this section, see § 83-19-87.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 109.	44 C.J.S., Insurance § 152.

§ 83-19-87. Certain purchases or sales of equity securities excepted.

The provisions of Section 83-19-83 shall not apply to any purchase and sale, or sale and purchase, and the provisions of Section 83-19-85 shall not apply to any sale, of an equity security of a domestic stock insurance company not then or theretofore held by him in an investment account, by a dealer in the ordinary course of his business and incident to the establishment or maintenance by him of a primary or secondary market (otherwise than on an exchange as defined in the Securities Exchange Act of 1934) for such security. The commissioner of insurance may, by such rules and regulations as he deems necessary or appropriate in the public interest, define and prescribe terms and conditions with respect to securities held in an investment account and transactions made in the ordinary course of business and incident to the establishment or maintenance of a primary or secondary market.

HISTORY: Codes, 1942, § 5670.7-04; Laws, 1966, ch. 528, § 4, eff from and after passage (approved March 17, 1966).

Federal Aspects — The Securities Exchange Act of 1934, see 15 USCS §§ 78a et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 105, 106.

CJS.
44 C.J.S., Insurance §§ 153-156.

§ 83-19-89. Certain arbitrage transactions excluded.

The provisions of Sections 83-19-81 through 83-19-85 shall not apply to foreign or domestic arbitrage transactions unless made in contravention of such rules and regulations as the commissioner of insurance may adopt in order to carry out the purposes of Sections 83-19-79 through 83-19-97.

HISTORY: Codes, 1942, § 5670.7-05; Laws, 1966, ch. 528, § 5, eff from and after passage (approved March 17, 1966).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 105, 106.

CJS.
44 C.J.S., Insurance §§ 153-156.

§ 83-19-91. Solicitation of proxies, consents, or authorizations.

It shall be unlawful for any person, in contravention of such rules and regulations as the commissioner of insurance may prescribe as necessary or appropriate in the public interest or for the protection of investors, to solicit or to permit the use of his name to solicit any proxy or consent or authorization in respect of any equity security of a domestic stock insurance company.

HISTORY: Codes, 1942, § 5670.7-06; Laws, 1966, ch. 528, § 6, eff from and after passage (approved March 17, 1966).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 63.

§ 83-19-93. Transmission of security information.

Unless proxies, consents, or authorizations in respect of an equity security of a domestic stock insurance company are solicited by or on behalf of the management of such company from the holders of record of such security in accordance with the rules and regulations prescribed under Section 83-19-91 prior to any annual or other meeting of the holders of such security, such company shall, in accordance with such rules and regulations as the commissioner of insurance may prescribe as necessary or appropriate in the public interest or for the protection of investors, if required thereby, file with the commissioner of insurance and transmit to all holders of record of such security information substantially equivalent to the information which would be required to be transmitted if a solicitation were made.

HISTORY: Codes, 1942, § 5670.7-07; Laws, 1966, ch. 528, § 7, eff from and after passage (approved March 17, 1966).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance § 96.

§ 83-19-95. Provisions inapplicable to certain equity securities.

The provisions of Sections 83-19-81, 83-19-83, 83-19-85, 83-19-91, and 83-19-93 shall not apply to equity securities of a domestic stock insurance company if (a) such securities shall be registered, or shall be required to be registered, pursuant to Section 12 of the Securities Exchange Act of 1934, as amended, or if (b) such domestic stock insurance company shall not have any class of its equity securities held of record by one hundred (100) or more persons on the last business day of the year next preceding the year in which equity securities of the company would be subject to the provisions of the cited sections except for the provisions of this subsection (b).

HISTORY: Codes, 1942, § 5670.7-09; Laws, 1966, ch. 528, § 9, eff from and after passage (approved March 17, 1966).

Federal Aspects — Section 12 of the Securities Exchange Act of 1934 is codified as 15 USCS § 78*l*.

§ 83-19-97. Commissioner to make rules and regulations.

The commissioner of insurance shall have the power to make such rules and regulations as may be necessary for the execution of the functions vested in him by Sections 83-19-81 through 83-19-93, and may for such purpose classify domestic stock insurance companies, securities, and other persons or matters within his jurisdiction. No provision of Sections 83-19-81, 83-19-83, 83-19-85, 83-19-91, and 83-19-93 imposing any liability shall apply to any act done or omitted in good faith in conformity with any rule or regulation of the commissioner of insurance, notwithstanding that such rule or regulation may, after such act or omission, be amended or rescinded or determined by judicial or other authority to be invalid for any reason.

HISTORY: Codes, 1942, § 5670.7-10; Laws, 1966, ch. 528, § 10, eff from and after passage (approved March 17, 1966).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

MERGER OR CONSOLIDATION, OR EXCHANGE OF OUTSTANDING STOCK, OF DOMESTIC STOCK COMPANIES

Sec.

83-19-99. Authorization.
83-19-101. Directors' resolution and plan.
83-19-103. Submission of plan to commissioner of insurance.
83-19-105. Public hearing on plan.
83-19-107. Commissioner's order.
83-19-109. Appeals from commissioner's decision.
83-19-111. Stockholder approval of plan.
83-19-113. Procedure where foreign corporation is involved.
83-19-115. Execution and filing of articles or agreement of exchange.
83-19-117. When stockholders' vote unnecessary.
83-19-119. Effect of merger or consolidation; when plan of exchange becomes effective; stock certificates.
83-19-121. Rights of dissenters.
83-19-123. Construction and effect of Sections 83-19-99 through 83-19-123.

§ 83-19-99. Authorization.

A domestic stock insurance company (referred to in Sections 83-19-99 through 83-19-123 as the "domestic company") may effect:

(a) A merger or consolidation with one or more domestic stock insurance companies, or with one or more foreign stock insurance companies, if such merger or consolidation is authorized by the laws of the state under which each such foreign company is organized; or

(b) An exchange of all the outstanding stock of its shareholders with a domestic stock corporation, or with a foreign stock corporation authorized to do business in this state, if such exchange is authorized by the laws of the state under which such foreign corporation is organized (such domestic or foreign corporation being referred to in Sections 83-19-99 through 83-19-123 as the "acquiring corporation"), which acquiring corporation pays or provides the following consideration: (1) shares of stock or other securities issued by such acquiring corporation; (2) cash; (3) other consideration; (4) any combination of such stock or other securities, cash or other consideration, by complying with the provisions of said sections.

Sections 83-19-99 through 83-19-123 shall be supplemental to the general laws of this state governing corporations but in the event there exists any conflict between the provisions of said sections and the provisions of the general laws governing corporations, the provisions of Sections 83-19-99 through 83-19-123 shall be controlling.

HISTORY: Codes, 1942, § 5670.7-21; Laws, 1972, ch. 419, § 1, eff from and after passage (approved April 27, 1972).

Cross References — Domestic mutual insurance company merger with foreign mutual insurance company, see § 83-31-47.

RESEARCH REFERENCES

CJS.
44 C.J.S., Insurance §§ 177 et seq.

Practice References.
Business Insurance Law and Practice Guide (Matthew Bender Elite Products).

Business Law Monographs (Matthew Bender Elite Products).

Liability of Corporate Officers and Directors, William E. Knepper, Dan A. Bailey, Stacy R. Lane, Katharine B. Bowman, Michael R. Goodstein, Darius N. Kandawalla (Matthew Bender).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-19-101. Directors' resolution and plan.

The constituent insurance companies may adopt a plan of merger or consolidation, or the domestic insurance company and the acquiring corporation may adopt a plan of exchange of stock in the manner hereinafter set out.

The board of directors of each such corporation shall adopt a resolution approved by a majority of the whole board setting forth the proposed plan of merger, consolidation or exchange and directing that it be submitted to a vote at a meeting of shareholders, which may be either an annual or a special meeting. The plan shall set forth:

(a) The name of each corporation which is a party to the plan and, if the name of any of them has been changed, the name under which it was formed; and the name of the surviving corporation or the name, or the method of determining it, of the consolidated corporation;

(b) The terms and conditions of the proposed merger, consolidation, or exchange of stock;

(c) The manner and basis of carrying such merger, consolidation, or exchange into effect; or

(d) In the case of a merger, a statement of any amendments or changes in the charter of the surviving corporation to be effected by such merger; in the case of a consolidation, all statements required to be included in the charter for a new corporation formed pursuant to the general laws of this state governing corporations.

No director, officer, agent or employee of any such corporation, shall receive any fee, commission, compensation or other valuable consideration whatsoever for in any manner aiding, promoting or assisting in the adoption or approval of such plan except as specifically set forth therein.

HISTORY: Codes, 1942, § 5670.7-22; Laws, 1972, ch. 419, § 2, eff from and after passage (approved April 27, 1972).

§ 83-19-103. Submission of plan to commissioner of insurance.

The constituent corporations in the case of a merger or consolidation, or the domestic company and the acquiring corporation in the case of an exchange of stock, shall then submit to the commissioner of insurance three (3) copies of the proposed plan certified by the president or a vice president of each as having been adopted by its board of directors in accordance with section 83-19-101, together with (a) financial statements of the constituent corporations, or of the domestic company and the acquiring corporation for its last preceding fiscal year; (b) pro forma financial statements of each such corporation based on the assumption that the plan was effective as proposed at the end of the last preceding fiscal year of the domestic company; (c) an estimate of expenses already incurred and of expenses expected to be incurred in connection with the proposed plan; (d) a written statement which sets forth for each such corporation the proposed changes, if any, in management policies and in the identity of its officers and directors, which are initially contemplated should the plan be effected as proposed; and (e) any other information which the commissioner may require with respect to such plan.

HISTORY: Codes, 1942, § 5670.7-22; Laws, 1972, ch. 419, § 2, eff from and after passage (approved April 27, 1972).

§ 83-19-105. Public hearing on plan.

The commissioner of insurance shall hold a public hearing upon the terms, conditions and provisions of the proposed plan of merger, consolidation or exchange to determine if it is reasonable, fair and in the public interest. At such hearing the shareholders and the policyholders of each such corporation, and any other interested parties, shall have the right to appear and to become parties to the proceeding.

Such hearing shall be commenced not less than thirty (30) days after the date on which such plan is submitted to the commissioner. The hearing shall be held at such place, date and time as the commissioner shall specify. Notice of the hearing shall be published in a newspaper having general circulation in the city or cities wherein are located the principal office of each corporation which is a party to the plan once a week for two (2) successive weeks, the last publication of such notice to be not more than two (2) weeks prior to the hearing date. Written notice of the hearing shall be mailed at least ten (10) days prior to the hearing by each such corporation to each of their respective shareholders. All expenses of publication shall be borne as specified in the plan.

HISTORY: Codes, 1942, § 5670.7-22; Laws, 1972, ch. 419, § 2, eff from and after passage (approved April 27, 1972).

§ 83-19-107. Commissioner's order.

The commissioner of insurance shall issue a written order approving the plan as submitted to him, including such modifications therein as a majority of the whole board of directors of each corporation which is a party to the plan shall approve, if he finds (a) that the plan, including all such modifications, if effected, will not tend to affect adversely the financial stability, management, general capacity, or intention to continue the safe and prudent transaction of insurance business of any domestic insurance company which is a party to the plan; (b) that the fulfillment of the plan will not affect either the contractual obligations of any domestic insurance company which is a party to the plan to its policyholders, or the ability and tendency of such company to render service to its policyholders in the future; and (c) that the terms and conditions of the plan are consistent with law and are fair and reasonable.

The order of the commissioner approving or disapproving the plan shall be filed within sixty (60) days after the date the plan is submitted to him. The commissioner shall give notice of such order to all parties to the proceeding and shall deliver copies thereof to each corporation which is a party to the plan.

HISTORY: Codes, 1942, § 5670.7-22; Laws, 1972, ch. 419, § 2, eff from and after passage (approved April 27, 1972).

§ 83-19-109. Appeals from commissioner's decision.

Any person becoming a party as hereinbefore provided and feeling aggrieved by the decision of the commissioner of insurance under the provisions of Sections 83-19-99 through 83-19-123 may appeal therefrom within thirty (30) days after the receipt of notice thereof to the Chancery Court of the First Judicial District of Hinds County by writ of certiorari upon giving bond with surety or sureties in such penalty as shall be approved by the chancery court of said county, conditioned that such appellant will pay all costs of the appeal in the event such appeal is unsuccessful. The said chancery court shall have the authority and jurisdiction to hear said appeal and to render its decision in regard thereto either in term time or vacation.

HISTORY: Codes, 1942, § 5670.7-22; Laws, 1972, ch. 419, § 2, eff from and after passage (approved April 27, 1972).

§ 83-19-111. Stockholder approval of plan.

The plan as approved by the commissioner of insurance shall then be submitted to a vote of the shareholders of each corporation which is a party to such plan at an annual or special meeting of such shareholders. Written notice of such meeting shall be given for the time and in the manner required by the general laws of this state governing corporate mergers. The written notice shall state the right of a shareholder to dissent and receive fair value for his shares, and shall contain a copy or summary of the plan of merger, consolidation, or exchange. The plan shall be approved upon receiving the affirmative votes of the holders of at least two-thirds (⅔) of the outstanding shares of capital stock of each such corporation, or of such larger proportion of shares as may be specified in the plan. Notwithstanding such approval and at any time prior to the effective date of the plan as provided in Section 83-19-119, it may be abandoned pursuant to provisions therefor, if any, set forth in the plan.

HISTORY: Codes, 1942, § 5670.7-22; Laws, 1972, ch. 419, § 2, eff from and after passage (approved April 27, 1972).

§ 83-19-113. Procedure where foreign corporation is involved.

If one (1) of the constituent corporations to a merger or consolidation is a foreign corporation, such merger or consolidation shall be carried out in the following manner: (a) each domestic corporation shall comply with the provisions of Sections 83-19-99 through 83-19-123 with respect to the merger or consolidation of domestic companies, and each foreign corporation shall comply with the applicable provisions of the laws of the state under which it is organized; (b) if the surviving or new corporation is to be governed by the laws of any state other than this state, it shall comply with the general laws of this state governing foreign corporations if it is to transact business or to conduct affairs in this state, and in every case it shall file with the secretary of state of this state an agreement that it may be served with process in this state in any proceeding for the enforcement of any obligation of any domestic corporation which is a party to such merger or consolidation and in any proceeding for the enforcement of the rights of a dissenting shareholder of any such domestic corporation against the surviving or consolidated corporation, and an irrevocable appointment of the secretary of state of this state as its agent to accept service of process in any such proceeding and an agreement that it will promptly pay to the dissenting shareholders of any such domestic corporation the amount, if any, to which they shall be entitled under Section 83-19-123.

The effect of such merger or consolidation shall be the same as in the case of the merger or consolidation of domestic corporations except insofar as the laws of the state governing such surviving or consolidated company provide otherwise.

In the case of an exchange of securities, if the acquiring corporation is a foreign corporation, then such corporation shall comply with the applicable provisions of the laws of the state under which it is organized. Such foreign acquiring corporation shall also procure a certificate of authority to transact business and conduct affairs in Mississippi and shall comply with all the provisions of the law of this state relating to foreign corporations. The effect of such exchange of securities shall be as provided by Sections 83-19-99 through 83-19-123 except insofar as the laws of the state under which such foreign acquiring corporation is organized provide otherwise.

HISTORY: Codes, 1942, § 5670.7-22; Laws, 1972, ch. 419, § 2, eff from and after passage (approved April 27, 1972).

§ 83-19-115. Execution and filing of articles or agreement of exchange.

(1) After the plan of merger or consolidation shall have been approved by the shareholders of each constituent corporation, appropriate articles of merger or consolidation shall be executed by the president or any vice

president and the secretary or any assistant secretary of each such corporation and filed in triplicate with the commissioner of insurance. If such articles of merger or consolidation show that the plan of merger or consolidation has been duly approved by the shareholders of each constituent corporation as required in Section 83-19-111 and otherwise conforms to the law, the commissioner shall endorse his approval on each copy of said articles, shall record one (1) copy in his office, and shall return the other two (2) copies to the domestic company for delivery to the secretary of state who will approve said merger or consolidation as provided by the general laws of this state governing corporations. Following that the certificate of merger or certificate of consolidation will be recorded in the office of the chancery clerk and published as required by the general laws of this state governing corporation.

(2) After the plan of exchange of stock shall have been approved by the shareholders of the domestic company and the acquiring corporation, an appropriate agreement of exchange shall be executed by the president or any vice president and the secretary or any assistant secretary of each such corporation and filed in triplicate with the commissioner of insurance. If such agreement shows that the plan of exchange has been duly approved by the shareholders of the domestic company and the acquiring corporation as required by Section 83-19-111 and otherwise conforms to the law, the commissioner shall endorse his approval on each copy thereof, shall record one (1) copy in his office, and shall return one (1) copy each to the domestic company and to the acquiring corporation.

HISTORY: Codes, 1942, § 5670.7-23; Laws, 1972, ch. 419, § 3, eff from and after passage (approved April 27, 1972).

§ 83-19-117. When stockholders' vote unnecessary.

If the domestic company owns at least ninety-five percent (95%) of the outstanding shares of another domestic or foreign stock insurance company, it may merge such other company into itself without approval by a vote of the shareholders of either company in accordance with the general laws of this state governing merger of subsidiary corporations. In such event, the approval of the commissioner of insurance shall be obtained in the manner specified in Sections 83-19-103 through 83-19-107.

HISTORY: Codes, 1942, § 5670.7-24; Laws, 1972, ch. 419, § 4, eff from and after passage (approved April 27, 1972).

§ 83-19-119. Effect of merger or consolidation; when plan of exchange becomes effective; stock certificates.

(1) The effect of the merger or consolidation shall be as provided in Section 79-4-11.07.

(2) The plan of exchange and the issuance and exchange of securities provided for therein shall become effective when the agreement of exchange has been recorded by the commissioner, or upon such later date as may be

specified in such agreement, which may not be later than thirty (30) days after such recording. Upon the plan of exchange becoming effective, the issuance and exchange of securities provided for therein shall be deemed to have been consummated, each shareholder of the domestic company shall cease to be a shareholder of such company and the ownership of all shares of the issued and outstanding stock of the domestic company shall vest in the acquiring corporation automatically without any physical transfer or deposit of certificates representing such shares.

Certificates representing shares of stock of the domestic company prior to the plan of exchange becoming effective shall, after the plan of exchange becomes effective, represent (a) shares of the issued and outstanding capital stock or other securities issued by the acquiring corporation; and (b) the right, if any, to receive such cash or other consideration upon such terms as shall be specified in the plan of exchange. Such certificates representing shares of stock of the domestic company may, after the plan of exchange becomes effective, be exchanged for shares of stock or other securities issued by the acquiring corporation or cash or other consideration or any combination thereof upon such terms as shall be specified in the plan of exchange.

HISTORY: Codes, 1942, § 5670.7-25; Laws, 1972, ch. 419, § 5; Laws, 1997, ch. 410, § 17, eff from and after July 1, 1997.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted “Section 79-4-11.07” for “Section 79-4-11.06” at the end of (1). The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-19-121. Rights of dissenters.

Any shareholder of any domestic stock insurance company which is a party to a merger, consolidation or exchange of securities as described in Sections 83-19-99 through 83-19-123 shall have the right to dissent and receive fair value for his shares by complying with the procedure set forth in Section 79-3-161, Mississippi Code of 1972.

HISTORY: Codes, 1942, § 5670.7-27; Laws, 1972, ch. 419, § 7, eff from and after passage (approved April 27, 1972).

Editor’s Notes — Section 79-3-161, referred to in this section, was repealed by Laws of 1987, ch. 486, § 17.06, effective January 1, 1988. For provisions governing dissenters’ rights, see §§ 79-4-13.01 et seq.

RESEARCH REFERENCES

ALR.

Timeliness and sufficiency of dissenting stockholder’s notice of his objection to consolidation or merger and of his demand for payment for his shares. 40 A.L.R.3d 260.

§ 83-19-123. Construction and effect of Sections 83-19-99 through 83-19-123.

Nothing contained in Sections 83-19-99 through 83-19-123 shall affect the power of the commissioner of insurance to regulate, supervise and control insurance companies to the extent of and as provided by Title 83, Mississippi Code of 1972. Nothing contained in Sections 83-19-99 through 83-19-123 shall be construed to authorize any insurance company to engage in any kinds of insurance business not authorized by its charter or to authorize any acquiring corporation which is not an insurance company to engage directly in the business of insurance. Subsequent to the effective date of any plan of exchange, the commissioner of insurance, having regard to the findings stated in Section 83-19-107, shall have authority to require that the affairs of the domestic company be conducted in such manner as to assure the continued safe conduct and transaction of the business of insurance of the domestic company.

HISTORY: Codes, 1942, § 5670.7-26; Laws, 1972, ch. 419, § 6, eff from and after passage (approved April 27, 1972).

REGULATION OF REINSURANCE

Sec.
83-19-151. Credit for reinsurance; accredited reinsurer defined.
83-19-153. Reduction from liability for reinsurance ceded by domestic insurer to assuming insurer not meeting requirements.
83-19-155. Definitions.
83-19-157. Adoption of rules and regulations.

§ 83-19-151. Credit for reinsurance; accredited reinsurer defined.

Credit for reinsurance shall be allowed a domestic ceding insurer as either an asset or a deduction from liability on account of reinsurance ceded only when the reinsurer meets the requirements of paragraph (a), (b), (c), (d), (e), (f) or (g) of this section; provided further that the commissioner may adopt by regulation pursuant to Section 83-19-157 specific additional requirements relating to or setting forth the valuation of assets or reserve credits, the amount and forms of security supporting reinsurance arrangements described in Section 83-19-157, and/or the circumstances pursuant to which credit will be reduced or eliminated. Credit shall be allowed under paragraph (a), (b) or (c) of this section only as respects cessions of those kinds or classes of business which the assuming insurer is licensed or otherwise permitted to write or assume in its state of domicile or, in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance. Credit shall be allowed under paragraph (c) or (d) of this section only if the applicable requirements of paragraph (h) have been satisfied.

(a) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is licensed to transact insurance or reinsurance in this state.

(b) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is accredited as a reinsurer in this state. In order to be eligible for accreditation, a reinsurer must:

(i) Files with the commissioner evidence of its submission to this state's jurisdiction;

(ii) Submits to this state's authority to examine its books and records;

(iii) Be licensed to transact insurance or reinsurance in at least one (1) state, or in the case of a United States branch of an alien assuming insurer, be entered through and licensed to transact insurance or reinsurance in at least one (1) state;

(iv) Files annually with the commissioner a copy of its annual statement filed with the Insurance Department of its state of domicile and a copy of its most recent audited financial statement; and

(v) Demonstrate to the satisfaction of the commissioner that it has adequate financial capacity to meet its reinsurance obligations and is otherwise qualified to assume reinsurance from domestic insurers. An assuming insurer is deemed to meet this requirement as of the time of its application if it maintains a surplus as regards policyholders in an amount not less than Twenty Million Dollars ($20,000,000.00) and its accreditation has not been denied by the commissioner within ninety (90) days after submission of its application.

(c)(i) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which is domiciled and licensed in, or in the case of a United States branch of an alien assuming insurer is entered through, a state which employs standards regarding credit for reinsurance substantially similar to those applicable under this statute and the assuming insurer or United States branch of an alien assuming insurer:

1. Maintains a surplus as regards policyholders in an amount not less than Twenty Million Dollars ($20,000,000.00); and

2. Submits to the authority of this state to examine its books and records.

(ii) The requirement of item 1 of this paragraph (c)(i) does not apply to reinsurance ceded and assumed pursuant to pooling arrangements among insurers in the same holding company system.

(d)(i) Credit shall be allowed when the reinsurance is ceded to an assuming insurer which maintains a trust fund in a qualified United States financial institution, as defined in paragraph (b) of Section 83-19-155, for the payment of the valid claims of its United States ceding insurers, their assigns and successors in interest. To enable the commissioner to determine the sufficiency of the trust fund, the assuming insurer shall report annually to the commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners annual statement form by licensed insurers. The assuming insurer shall submit to examination of its books and records by the commissioner and bear the expense of examination.

(ii)1. Credit for reinsurance shall not be granted under this paragraph (d) unless the form of the trust and any amendments to the trust have been approved by:

a. The commissioner of the state where the trust is domiciled; or

b. The commissioner of another state who, pursuant to the terms of the trust instrument, has accepted principal regulatory oversight of the trust.

2. The form of the trust and any trust amendments also shall be filed with the commissioner of every state in which the ceding insurer beneficiaries of the trust are domiciled. The trust instrument shall provide that contested claims shall be valid and enforceable upon the final order of any court of competent jurisdiction in the United States. The trust shall vest legal title to its assets in its trustees for the benefit of the assuming insurer's United States ceding insurers, their assigns and successors in interest. The trust and the assuming insurer shall be subject to examination as determined by the commissioner.

3. The trust shall remain in effect for as long as the assuming insurer has outstanding obligations due under the reinsurance agreements subject to the trust. No later than February 28 of each year the trustee of the trust shall report to the commissioner in writing the balance of the trust and listing the trust's investments at the preceding year-end and shall certify the date of termination of the trust, if so planned, or certify that the trust will not expire prior to the following December 31.

(iii) The following requirements apply to the following categories of assuming insurer:

1. The trust fund for a single assuming insurer shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers, and, in addition, the assuming insurer shall maintain a trusteed surplus of not less than Twenty Million Dollars ($20,000,000.00) except as provided in item 2 of this paragraph (d)(iii).

2. At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three (3) full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders and claimants in light of reasonably foreseeable adverse loss development. The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including when applicable the lines of business involved, the stability of the incurred loss estimates and the effect of the surplus requirements on the assuming insurer's liquidity or solvency. The minimum required trusteed surplus may not be reduced to an amount less than thirty percent

(30%) of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

3.a. In the case of a group including incorporated and individual unincorporated underwriters:

A. For reinsurance ceded under reinsurance agreements with an inception, amendment or renewal date on or after January 1, 1993, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by United States domiciled ceding insurers to any underwriter of the group;

B. For reinsurance ceded under reinsurance agreements with an inception date on or before December 31, 1992, and not amended or renewed after that date, notwithstanding the other provisions of Sections 83-19-151 through 83-19-157, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States; and

C. In addition to these trusts, the group shall maintain in trust a trusteed surplus of which One Hundred Million Dollars ($100,000,000.00) shall be held jointly for the benefit of the United States domiciled ceding insurers of any member of the group for all years of account; and

b. The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members.

c. Within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the group.

(iv) In the case of a group of incorporated underwriters under common administration, the group shall:

1. Have continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to making application for accreditation;

2. Maintain aggregate policyholders' surplus of at least Ten Billion Dollars ($10,000,000,000.00);

3. Maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by United States domiciled ceding insurers to any member of the group pursuant to reinsurance contracts issued in the name of the group;

4. In addition, maintain a joint trusteed surplus of which One Hundred Million Dollars ($100,000,000.00) shall be held jointly for the

benefit of United States domiciled ceding insurers of any member of the group as additional security for these liabilities; and

5. Within ninety (90) days after its financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner an annual certification of each underwriter member's solvency by the member's domiciliary regulator and financial statements of each underwriter member of the group prepared by its independent public accountant.

(e) Credit shall be allowed when the reinsurance is ceded to an assuming insurer that has been certified by the commissioner as a reinsurer in this state and secures its obligations in accordance with the requirements of this paragraph (e).

(i) In order to be eligible for certification, the assuming insurer shall meet the following requirements:

1. The assuming insurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction, as determined by the commissioner pursuant to subparagraph (iii) of this paragraph (e);

2. The assuming insurer must maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the commissioner pursuant to regulation;

3. The assuming insurer must maintain financial strength ratings from two (2) or more rating agencies deemed acceptable by the commissioner pursuant to regulation;

4. The assuming insurer must agree to submit to the jurisdiction of this state, appoint the commissioner as its agent for service of process in this state, and agree to provide security for one hundred percent (100%) of the assuming insurer's liabilities attributable reinsurance ceded by United States ceding insurers if it resists enforcement of a final United States judgment;

5. The assuming insurer must agree to meet applicable information filing requirements as determined by the commissioner, both with respect to an initial application for certification and on an ongoing basis; and

6. The assuming insurer must satisfy any other requirements for certification deemed relevant by the commissioner.

(ii) An association including incorporated and individual unincorporated underwriters may be a certified reinsurer. In order to be eligible for certification, in addition to satisfying requirements of subparagraph (i) of this paragraph (e):

1. The association shall satisfy its minimum capital and surplus requirements through the capital and surplus equivalents (net of liabilities) of the association and its members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of its members, in an amount determined by the commissioner to provide adequate protection;

2. The incorporated members of the association shall not be engaged in any business other than underwriting as a member of the association and shall be subject to the same level of regulation and solvency control by the association's domiciliary regulator as are the unincorporated members; and

3. Within ninety (90) days after its financial statements are due to be filed with the association's domiciliary regulator, the association shall provide to the commissioner an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or if a certification is unavailable, financial statements, prepared by independent public accountants, of each underwriter member of the association.

(iii) The commissioner shall create and publish a list of qualified jurisdictions, under which an assuming insurer licensed and domiciled in such jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer.

1. In order to determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis, and consider the rights, benefits and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States. A qualified jurisdiction must agree to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction. A jurisdiction may not be recognized as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards. Additional factors may be considered in the discretion of the commissioner.

2. A list of qualified jurisdictions shall be published through the NAIC Committee Process. The commissioner shall consider this list in determining qualified jurisdictions. If the commissioner approves a jurisdiction as qualified that does not appear on the list of qualified jurisdictions, the commissioner shall provide thoroughly documented justification in accordance with criteria to be developed under regulations.

3. United States jurisdictions that meet the requirement for accreditation under the NAIC Financial Regulation Standards and Accreditation Program shall be recognized as qualified jurisdictions.

4. If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner has the discretion to suspend the reinsurer's certification indefinitely, in lieu of revocation.

(iv) The commissioner shall assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies deemed acceptable to the commissioner pursuant to regulation. The commissioner shall publish a list of all certified reinsurers and their ratings.

(v) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this paragraph (e) at a level consistent with its rating, as specified in regulations promulgated by the commissioner.

1. In order for a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the commissioner and consistent with the provisions of Section 83-19-153 or in a multibeneficiary trust in accordance with paragraph (d) of this section, except as otherwise provided in this paragraph (e).

2. If a certified reinsurer maintains a trust to fully secure its obligations subject to paragraph (d) of this section, and chooses to secure its obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for its obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this paragraph (e) or comparable laws of other United States jurisdictions and for its obligations subject to paragraph (d) of this section. It shall be a condition to the grant of certification under this paragraph (e) that the certified reinsurer shall have bound itself, by the language of the trust and agreement with the commissioner with principal regulatory oversight of each such trust account, to fund, upon termination of any such trust account, out of the remaining surplus of such trust any deficiency of any other such trust account.

3. The minimum trusteed surplus requirements provided in paragraph (d) of this section are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this paragraph (e), except that such trust shall maintain a minimum trusteed surplus of Ten Million Dollars ($10,000,000.00).

4. With respect to obligations incurred by a certified reinsurer under this paragraph, if the security is insufficient, the commissioner shall reduce the allowable credit by an amount proportionate to the deficiency, and has the discretion to impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

5. For purposes of this paragraph, a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure one hundred percent (100%) of its obligations.

6. As used in this paragraph (e), the term "terminated" refers to revocation, suspension, voluntary surrender and inactive status.

7. If the commissioner continues to assign a higher rating as permitted by other provisions of this section, this requirement does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(vi) If an applicant for certification has been certified as a reinsurer in an NAIC accredited jurisdiction, the commissioner has the discretion to defer to that jurisdiction's certification, and has the discretion to defer to the rating assigned by that jurisdiction, and such assuming insurer shall be considered to be a certified reinsurer in this state.

(vii) A certified reinsurer that ceases to assume new business in this state may request to maintain its certification in inactive status in order to continue to qualify for a reduction in security for its in-force business. An inactive certified reinsurer shall continue to comply with all applicable requirements of this paragraph (e), and the commissioner shall assign a rating that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(f)(i) Credit shall be allowed when the reinsurance is ceded to an assuming insurer meeting each of the conditions set forth below.

1. The assuming insurer must have its head office or be domiciled in, as applicable, and be licensed in a Reciprocal Jurisdiction. A "Reciprocal Jurisdiction" is a jurisdiction that meets one (1) of the following:

a. A non-U.S. jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union. For purposes of this paragraph (f), a "covered agreement" is an agreement entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. Sections 313 and 314, that is currently in effect or in a period of provisional application and addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance;

b. A U.S. jurisdiction that meets the requirements for accreditation under the NAIC financial standards and accreditation program; or

c. A qualified jurisdiction, as determined by the commissioner pursuant to paragraph (e)(iii) of this section which is not otherwise described in item 1.a or 1.b above and which meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the commissioner in regulation.

2. The assuming insurer must have and maintain on an ongoing basis minimum capital and surplus, or its equivalent, calculated according to the methodology of its domiciliary jurisdiction, in an amount to be determined by the commissioner pursuant to regulation. If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain on an ongoing basis minimum capital and surplus equivalents (net of liabilities), calculated according to the methodology applicable in its domiciliary

jurisdiction, and a central fund containing a balance in amounts to be determined by the commissioner pursuant to regulation.

3. The assuming insurer must have and maintain on an ongoing basis a minimum solvency or capital ratio, as applicable, to be determined by the commissioner pursuant to regulation. If the assuming reinsurer is an association, including incorporated and individual unincorporated underwriters, it must have and maintain on an ongoing basis a minimum solvency or capital ratio in the Reciprocal Jurisdiction where the assuming reinsurer has its head office or is domiciled, as applicable, and is also licensed.

4. The assuming insurer must agree and provide adequate assurance to the commissioner, in a form specified by the commissioner pursuant to regulation, as follows:

a. The assuming insurer must provide prompt written notice and explanation to the commissioner if it falls below the minimum requirements set forth in items 2 and 3 of this subparagraph (i), or if any regulatory action is taken against it for serious noncompliance with applicable law;

b. The assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process. The commissioner may also require that such consent be provided and included in each reinsurance agreement under the commissioner's jurisdiction. Nothing in this provision shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

c. The assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or its legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

d. Each reinsurance agreement must include a provision requiring the assuming reinsurer to provide security in an amount equal to one hundred percent (100%) of the assuming reinsurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming reinsurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which it was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by its legal successor on behalf of its resolution estate; and

e. The assuming insurer must confirm that it is not presently participating in any solvent scheme of arrangement which involves this state's ceding insurers, and agrees to notify the ceding insurer and the commissioner and to provide security in an amount equal to one hundred percent (100%) of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement. Such security shall be in a form consistent with the provisions of paragraph (e) of this section and Section 83-19-153 and as specified by the commissioner's regulation.

5. The assuming insurer or its legal successor must provide, if requested by the commissioner, on behalf of itself and any legal predecessors, certain documentation to the commissioner as specified by the commissioner in regulation.

6. The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in regulation.

7. The assuming insurer's supervisory authority must confirm to the commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the Reciprocal Jurisdiction, that the assuming reinsurer complies with the requirements set forth in items 2 and 3.

8. Nothing in this provision precludes an assuming insurer from providing the commissioner with information on a voluntary basis.

(ii) The commissioner shall timely create and publish a list of Reciprocal Jurisdictions.

1. A list of Reciprocal Jurisdictions is published through the NAIC Committee Process. The commissioner's list shall include any Reciprocal Jurisdiction as defined under subparagraph (i)1.a and b of this paragraph (f) and shall consider any other Reciprocal Jurisdiction included on the NAIC list. The commissioner may approve a jurisdiction that does not appear on the NAIC list of Reciprocal Jurisdictions in accordance with criteria to be developed under regulations issued by the commissioner.

2. The commissioner may remove a jurisdiction from the list of Reciprocal Jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a Reciprocal Jurisdiction in accordance with a process set forth in regulations issued by the commissioner, except that the commissioner shall not remove from the list a Reciprocal Jurisdiction as defined under subparagraph (i)1.a and b of this paragraph (f). Upon removal of a Reciprocal Jurisdiction from this list credit for reinsurance ceded to an assuming insurer which has its home office or is domiciled in that jurisdiction shall be allowed, if otherwise allowed pursuant to this section.

(iii) The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this paragraph (f) and to which cessions shall be granted credit in accordance with this paragraph (f). The commissioner may add an assuming insurer to such list if an NAIC accredited jurisdiction has added such assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under subparagraph (i)4 of this paragraph (f) and complies with any additional requirements that the commissioner may impose by regulation, except to the extent that they conflict with an applicable covered agreement.

(iv) If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this paragraph (f), the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this paragraph (f) in accordance with procedures set forth in regulation.

1. While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended or renewed after the effective date of the suspension qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with Section 83-19-153.

2. If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the effective date of the revocation with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into prior to the date of revocation, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of Section 83-19-153.

(v) If subject to a legal process of rehabilitation, liquidation or conservation, as applicable, the ceding insurer, or its representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(vi) Nothing in this paragraph (f) shall limit or in any way alter the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this section or other applicable law or regulation.

(vii) Credit may be taken under this paragraph (f) only for reinsurance agreements entered into, amended, or renewed on or after July 1, 2020, and only with respect to losses incurred and reserves reported on or after the later of (i) the date on which the assuming insurer has met all eligibility requirements pursuant to subparagraph (i) of this paragraph (f), or (ii) the effective date of the new reinsurance agreement, amendment or renewal.

1. This subparagraph (vii) does not alter or impair a ceding insurer's right to take credit for reinsurance to the extent that credit is not available under this paragraph (f), as long as the reinsurance qualifies for credit under any other applicable provision of this section.

2. Nothing in this paragraph (f) shall authorize an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

3. Nothing in this paragraph (f) shall limit, or in any way alter, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(g) Credit shall be allowed when the reinsurance is ceded to an assuming insurer not meeting the requirements of paragraph (a), (b), (c), (d),

(e) or (f) of this section, but only as to the insurance of risks located in jurisdictions where the reinsurance is required by applicable law or regulation of that jurisdiction.

(h) If the assuming insurer is not licensed, accredited or certified to transact insurance or reinsurance in this state, the credit permitted by paragraphs (c) and (d) of this section shall not be allowed unless the assuming insurer agrees in the reinsurance agreements:

(i)1. That in the event of the failure of the assuming insurer to perform its obligations under the terms of the reinsurance agreement, the assuming insurer, at the request of the ceding insurer, shall submit to the jurisdiction of any court of competent jurisdiction in any state of the United States, will comply with all requirements necessary to give the court jurisdiction, and will abide by the final decision of the court or of any appellate court in the event of an appeal; and

2. To designate the commissioner or a designated attorney as its true and lawful attorney upon whom may be served any lawful process in any action, suit or proceeding instituted by or on behalf of the ceding insurer.

(ii) This paragraph (h) is not intended to conflict with or override the obligation of the parties to a reinsurance agreement to arbitrate their disputes, if this obligation is created in the agreement.

(i) If the assuming insurer does not meet the requirements of paragraph (a), (b), (c) or (f) of this section the credit permitted by paragraph (d) or (e) of this section shall not be allowed unless the assuming insurer agrees in the trust agreements to the following conditions:

(i) Notwithstanding any other provisions in the trust instrument, if the trust fund is inadequate because it contains an amount less than the amount required by paragraph (d)(iii) of this section, or if the grantor of the trust has been declared insolvent or placed into receivership, rehabilitation, liquidation or similar proceedings under the laws of its state or country of domicile, the trustee shall comply with an order of the commissioner with regulatory oversight over the trust or with an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

(ii) The assets shall be distributed by and claims shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of domestic insurance companies.

(iii) If the commissioner with regulatory oversight determines that the assets of the trust fund or any part thereof are not necessary to satisfy the claims of the United States ceding insurers of the grantor of the trust, the assets or part thereof shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust agreement.

(iv) The grantor shall waive any right otherwise available to it under United States law that is inconsistent with this provision.

(j) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification.

(i) The commissioner must give the reinsurer notice and opportunity for hearing. The suspension or revocation may not take effect until after the commissioner's order on hearing, unless:

1. The reinsurer waives its right to hearing;

2. The commissioner's order is based on regulatory action by the reinsurer's domiciliary jurisdiction or the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or in the primary certifying state of the reinsurer under paragraph (e)(vi) of this section; or

3. The commissioner finds that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

(ii) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with Section 83-19-153. If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with paragraph (e)(v) of this section or Section 83-19-153.

(k) Concentration risk.

(i) A ceding insurer shall take steps to manage its reinsurance recoverables proportionate to its own book of business. A domestic ceding insurer shall notify the commissioner within thirty (30) days after reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, exceeds fifty percent (50%) of the domestic ceding insurer's last-reported surplus to policyholders, or after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(ii) A ceding insurer shall take steps to diversify its reinsurance program. A domestic ceding insurer shall notify the commissioner within thirty (30) days after ceding to any single assuming insurer, or group of affiliated assuming insurers, more than twenty percent (20%) of the ceding insurer's gross written premium in the prior calendar year, or after it has determined that the reinsurance ceded to any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed this limit. The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

HISTORY: Laws, 1991, ch. 501, § 1; Laws, 1994, ch. 333, § 1; Laws, 2017, ch. 306, § 8, eff from and after passage (approved Mar. 6, 2017); Laws, 2020, ch. 316, § 1, eff from and after July 1, 2020.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected errors in internal references throughout the section as follows: substituted "this paragraph (d)" for "this subsection" in (d)(ii)1; substituted "this paragraph (e)" for "this subsection" in (e), (e)(v), (e)(v)1, (e)(v)2, (e)(v)3, (e)(v)4, (e)(v)5, (e)(v)6 and (e)(vii); substituted "this section" for "this subsection" in (e)(v)1, (e)(v)2, (e)(V)3, (g), (h), (i), (i)(i), (j)(i)2 and (j)(iii); substituted "or (ii) the effective date of" for "and (ii) the effective date of" in (f)(vii); and substituted "This paragraph (h)" for "This subsection" in (h)(ii). The Joint Committee ratified the correction at its October 19, 2020, meeting.

Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "paragraph (d) or (e) of this section" for "paragraph (d) or (e) of this subsection" in (i). The Joint Committee ratified the correction at its August 10, 2022, meeting.

Editor's Notes — Laws of 1991, ch. 501, § 5, provides as follows:

"SECTION 5. Sections 1 through 4 [codified as §§ 83-19-151 through 83-19-157] shall apply to all cessions after July 1, 1991, under reinsurance agreements which have had an inception, anniversary or renewal date not less than six (6) months after such date."

Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides:

"SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

Cross References — Annual reports of reinsurance contracts, see § 83-5-57.

Fire risks, see § 83-13-1.

JUDICIAL DECISIONS

Analysis

1.-5. [Reserved for future use.]
6. Under former § 83-19-71.

1.-5. [Reserved for future use.]

6. Under former § 83-19-71.

A provision in a life insurance policy, issued upon the applicant's statement without examination of the applicant by a physician, that if the insured was not in sound health on the date thereof the insurer's liability should be limited to a return of the premiums received under the policy, could not be construed as meaning a change for the worse in the condition of health from the date of the acceptance of the application to the date of the actual delivery of the policy. National Life & Acci. Ins. Co. v. Green, 191 Miss. 581, 2 So. 2d 838, 3 So. 2d 812, 1941 Miss. LEXIS 162 (Miss. 1941).

RESEARCH REFERENCES

ALR.

Reinsurer's liability for primary liability insurer's failure to compromise or settle. 40 A.L.R.4th 1130.

Liability insurance: excess carrier's right of action against primary carrier for improper or inadequate defense of claim. 49 A.L.R.4th 305.

Who May Enforce Liability of Reinsurer. 87 A.L.R.6th 319.

Am. Jur.

14A Am. Jur. Pl & Forms (Rev), Insurance, Form No. 1081 (complaint or declaration for recovery on reinsurance policy-by primary insurer against reinsurer)

Form No. 1082 (complaint or declaration for recovery on life insurance policy-by widow of insured-against reinsurer who assumed obligation of original insurer).

44A Am. Jur. 2d, Insurance §§ 1809, 1814 et seq.

14A Am. Jur. Pl & Forms (Rev), Insurance, Form No. 1081 (complaint or declaration for recovery on reinsurance policy-by primary insurer against reinsurer); Form No. 1082 (complaint or declaration for recovery on life insurance policy-by widow of insured-against reinsurer who assumed obligation of original insurer).

10 Am. Jur. Legal Forms 2d, Insurance § 149:44.

CJS.

46 C.J.S., Insurance §§ 1720 et seq.

Practice References.

Business Insurance Law and Practice Guide (Matthew Bender Elite Products).

Business Law Monographs (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-19-153. Reduction from liability for reinsurance ceded by domestic insurer to assuming insurer not meeting requirements.

An asset or reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Section 83-19-151 shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer, provided that the commissioner may adopt by regulation pursuant to Section 83-19-157(2) specific additional requirements relating to or setting forth: (i) the valuation of assets or reserves credits; (ii) the amount and forms of security supporting reinsurance arrangements described in Section 83-19-157(2); and/or (iii) the circumstances pursuant to which the credit will be reduced or eliminated. The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with such assuming insurer as security for the payment of obligations thereunder, if such security is held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or, in the case of a trust, held in a qualified United States financial institution, as defined in paragraph (b) of Section 83-19-155. This security may be in the form of:

(a) Cash;

(b) Securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

(c)(i) Clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution, as defined in paragraph (a) of Section 83-19-155, effective no later than December 31 in respect of the year for which filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement.

(ii) Letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

(d) Any other form of security acceptable to the commissioner.

HISTORY: Laws, 1991, ch. 501, § 2; Laws, 2017, ch. 306, § 9, eff from and after passage (approved Mar. 6, 2017).

Editor's Notes — Although paragraph (c) of this section refers to "letters of credit, as defined in paragraph (a)," there is no definition of "letters of credit" in Sections 83-19-151 through 83-19-157.

Section 5, ch. 501, Laws of 1991, provides as follows:

"SECTION 5. Sections 1 through 4 [codified as §§ 83-19-151 through 83-19-157] shall apply to all cessions after July 1, 1991, under reinsurance agreements which have had an inception, anniversary or renewal date not less than six (6) months after such date."

Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides:

"SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-19-155. Definitions.

(a) For purposes of paragraph (c) of Section 83-19-153, a "qualified United States financial institution" means an institution that:

(i) Is organized or (in the case of a United States office of a foreign banking organization) licensed, under the laws of the United States or any state thereof;

(ii) Is regulated, supervised and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(iii) Has been determined by either the commissioner, or the Securities Valuation Office of the National Association of Insurance Commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

(b) A "qualified United States financial institution" means, for purposes of those provisions of this law specifying those institutions that are eligible to act as a fiduciary of a trust, an institution that:

(i) Is organized, or (in the case of a United States branch or agency office of a foreign banking organization) licensed, under the laws of the United States or any state thereof and has been granted authority to operate with fiduciary powers; and

(ii) Is regulated, supervised and examined by federal or state authorities having regulatory authority over banks and trust companies.

HISTORY: Laws, 1991, ch. 501, § 3, eff from and after July 1, 1991.

Editor's Notes — Section 5, ch. 501, Laws of 1991, provides as follows:

"SECTION 5. Sections 1 through 4 [codified as §§ 83-19-151 through 83-19-157] shall apply to all cessions after July 1, 1991, under reinsurance agreements which have had an inception, anniversary or renewal date not less than six (6) months after such date."

§ 83-19-157. Adoption of rules and regulations.

(1) The commissioner may adopt rules and regulations implementing the provisions of Sections 83-19-151 through 83-19-157.

(2) The commissioner is further authorized to adopt rules and regulations applicable to reinsurance arrangements described in paragraph (a) of this subsection (2).

(a) A regulation adopted pursuant to this subsection (2) may apply only to reinsurance relating to:

(i) Life insurance policies with guaranteed nonlevel gross premiums or guaranteed nonlevel benefits;

(ii) Universal life insurance policies with provisions resulting in the ability of a policyholder to keep a policy in force over a secondary guarantee period;

(iii) Variable annuities with guaranteed death or living benefits;

(iv) Long-term care insurance policies; or

(v) Such other life and health insurance and annuity products as to which the NAIC adopts model regulatory requirements with respect to credit for reinsurance.

(b) A regulation adopted pursuant to paragraph (a)(i) or (ii) of this subsection (2) may apply to any treaty containing (i) policies issued on or after January 1, 2015, and/or (ii) policies issued prior to January 1, 2015, if risk pertaining to such pre-2015 policies is ceded in connection with the treaty, in whole or in part, on or after January 1, 2015.

(c) A regulation adopted pursuant to this subsection (2) may require the ceding insurer, in calculating the amounts or forms of security required to be held under regulations promulgated under this authority, to use the Valuation Manual adopted by the NAIC under Section 83-7-23(11)(b)(i), including all amendments adopted by the NAIC and in effect on the date as of which the calculation is made, to the extent applicable.

(d) A regulation adopted pursuant to this subsection (2) shall not apply to cessions to an assuming insurer that:

(i) Meets the conditions set forth in Section 83-19-151(f) in this state or, if this state has not adopted provisions substantially equivalent to Section 83-19-151(f), the assuming insurer is operating in accordance with provisions substantially equivalent to Section 83-19-151(f) in a minimum of five (5) other states;

(ii) Is certified in this state or, if this state has not adopted provisions substantially equivalent to Section 83-19-151(e), certified in a minimum of five (5) other states; or

(iii) Maintains at least Two Hundred Fifty Million Dollars ($250,000,000.00) in capital and surplus when determined in accordance with the NAIC Accounting Practices and Procedures Manual, including all amendments thereto adopted by the NAIC, excluding the impact of any permitted or prescribed practices; and is:

1. Licensed in at least twenty-six (26) states; or
2. Licensed in at least ten (10) states, and licensed or accredited in a total of at least thirty-five (35) states.

(e) The authority to adopt regulations pursuant to this subsection (2) does not limit the commissioner's general authority to adopt regulations pursuant to subsection (1) of this section.

HISTORY: Laws, 1991, ch. 501, § 4; Laws, 2017, ch. 306, § 10, eff from and after passage (approved Mar. 6, 2017); Laws, 2020, ch. 316, § 2, eff from and after July 1, 2020.

Editor's Notes — Section 5, ch. 501, Laws of 1991, provides as follows:

"SECTION 5. Sections 1 through 4 [codified as §§ 83-19-151 through 83-19-157] shall apply to all cessions after July 1, 1991, under reinsurance agreements which have had an inception, anniversary or renewal date not less than six (6) months after such date."

Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides:

"SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

REINSURANCE INTERMEDIARY ACT

Sec.
83-19-201. Short title.
83-19-203. Definitions.
83-19-205. Persons prohibited from acting as reinsurance intermediary broker; persons prohibited from acting as reinsurance intermediary manager; requirements of reinsurance intermediary managers; reinsurance intermediary license; conditions; grounds for refusal to issue license; exceptions to requirements of section.
83-19-207. Written authorization required for transactions between reinsurance intermediary broker and insurer; minimum contents of authorization.
83-19-209. Records required to be kept by reinsurance intermediary broker; right of insurer to access, copy and audit records.
83-19-211. Required and prohibited acts of insurer with respect to reinsurance intermediary brokers.
83-19-213. Written contract required for transactions between reinsurance intermediary manager and reinsurer; filing of contract; minimum contents of contract.
83-19-215. Prohibited acts of reinsurance intermediary manager.
83-19-217. Required and prohibited acts of reinsurer with respect to reinsurance intermediary managers.
83-19-219. Examination of reinsurance intermediary by commissioner; reinsurance intermediary manager examined as reinsurer; commissioner to adopt rules and regulations.
83-19-221. Penalties for violations of §§ 83-19-201 through 83-19-221.

§ 83-19-201. Short title.

Sections 83-19-201 through 83-19-221 may be cited as the Reinsurance Intermediary Act.

HISTORY: Laws, 1992, ch. 330, § 1, eff from and after July 1, 1992.

RESEARCH REFERENCES

ALR.
Who May Enforce Liability of Reinsurer. 87 A.L.R.6th 319.

Am. Jur.
44A Am. Jur. 2d, Insurance §§ 1809-1825.

Practice References.
Business Law Monographs, Volume IN1—Business Uses of Life Insurance (Matthew Bender Elite Products).

§ 83-19-203. Definitions.

As used in Sections 83-19-201 through 83-19-221:

(a) "Actuary" means a person who is a member in good standing of the American Academy of Actuaries.

(b) "Controlling person" means any person, firm, association or corporation who directly or indirectly has the power to direct, or cause to be directed, the management, control or activities of the reinsurance intermediary.

(c) "Insurer" means any person, firm, association or corporation duly licensed in this state pursuant to the applicable provisions of the insurance law as an insurer.

(d) "Licensed producer" means an agent, broker or reinsurance intermediary licensed pursuant to the applicable provision of the insurance law.

(e) "Reinsurance intermediary" means a reinsurance intermediary broker or a reinsurance intermediary manager as these terms are defined in paragraphs (f) and (g).

(f) "Reinsurance intermediary broker" means any person, other than an officer or employee of the ceding insurer, firm, association or corporation who solicits, negotiates or places reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power to bind reinsurance on behalf of such insurer.

(g) "Reinsurance intermediary manager" means any person, firm, association or corporation who has authority to bind or manages all or part of the assumed reinsurance business of a reinsurer (including the management of a separate division, department or underwriting office) and acts as an agent for such reinsurer whether known as a reinsurance intermediary manager, manager or other similar term. Notwithstanding the above, the following persons shall not be considered a reinsurance intermediary manager, with respect to such reinsurer, for the purposes of §§ 83-19-201 through 83-19-221:

(i) An employee of the reinsurer;

(ii) A United States manager of the United States branch of an alien reinsurer;

(iii) An underwriting manager who, pursuant to contract, manages all the reinsurance operations of the reinsurer, is under common control with the reinsurer, subject to the Holding Company Act, and whose compensation is not based on the volume of premiums written;

(iv) The manager of a group, association, pool or organization of insurers who engage in joint underwriting or joint reinsurance and who are subject to examination by the insurance commissioner of the state in which the manager's principal business office is located.

(h) "Reinsurer" means any person, firm, association or corporation duly licensed in this state pursuant to the applicable provisions of the insurance law as an insurer with the authority to assume reinsurance.

(i) "To be in violation" means that the reinsurance intermediary, insurer or reinsurer for whom the reinsurance intermediary was acting failed to substantially comply with Sections 83-19-201 through 83-19-221.

(j) "Qualified United States financial institution" means an institution that:

(i) Is organized or (in the case of a United States office of a foreign banking organization) licensed, under the laws of the United States or any state thereof;

(ii) Is regulated, supervised and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

(iii) Has been determined by either the commissioner, or the Securities Valuation Office of the National Association of Insurance Commissioners, to meet such standards of financial condition and standing as are considered necessary and appropriate to regulate the quality of financial institutions whose letters of credit will be acceptable to the commissioner.

HISTORY: Laws, 1992, ch. 330 § 2, eff from and after July 1, 1992.

§ 83-19-205. Persons prohibited from acting as reinsurance intermediary broker; persons prohibited from acting as reinsurance intermediary manager; requirements of reinsurance intermediary managers; reinsurance intermediary license; conditions; grounds for refusal to issue license; exceptions to requirements of section.

(1) No person, firm, association or corporation shall act as a reinsurance intermediary broker in this state if the reinsurance intermediary broker maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation:

(a) In this state, unless such reinsurance intermediary broker is a licensed producer in this state; or

(b) In another state, unless such reinsurance intermediary broker is a licensed producer in this state or another state having a law substantially similar to this law or such reinsurance intermediary broker is licensed in this state as a nonresident reinsurance intermediary.

(2) No person, firm, association or corporation shall act as a reinsurance intermediary manager:

(a) For a reinsurer domiciled in this state, unless such reinsurance intermediary manager is a licensed producer in this state;

(b) In this state, if the reinsurance intermediary manager maintains an office either directly or as a member or employee of a firm or association, or an officer, director or employee of a corporation in this state, unless such reinsurance intermediary manager is a licensed producer in this state;

(c) In another state for a nondomestic insurer, unless such reinsurance intermediary manager is a licensed producer in this state or another state having a law substantially similar to this law or such person is licensed in this state as a nonresident reinsurance intermediary.

(3) The commissioner may require a reinsurance intermediary manager subject to subsection (2) to:

(a) File a bond in an amount from an insurer acceptable to the commissioner for the protection of the reinsurer; and

(b) Maintain an errors and omissions policy in an amount acceptable to the commissioner.

(4)(a) The commissioner may issue a reinsurance intermediary license to any person, firm, association or corporation who has complied with the requirements of Sections 83-19-201 through 83-19-221. Any such license issued to a firm or association will authorize all the members of such firm or association and any designated employees to act as reinsurance intermediaries under the license, and all such persons shall be named in the application and any supplements thereto. Any such license issued to a corporation shall authorize all of the officers, and any designated employees and directors thereof to act as reinsurance intermediaries on behalf of such corporation, and all such persons shall be named in the application and any supplements thereto.

(b) If the applicant for a reinsurance intermediary license is a nonresident, such applicant, as a condition precedent to receiving or holding a license, shall designate the commissioner as agent for service of process in the manner, and with the same legal effect, provided for by Sections 83-19-201 through 83-19-221 for designation of service of process upon unauthorized insurers; and also shall furnish the commissioner with the name and address of a resident of this state upon whom notices or orders of the commissioner or process affecting such nonresident reinsurance intermediary may be served. Such licensee shall promptly notify the commissioner in writing of every change in its designated agent for service of process, and such change shall not become effective until acknowledged by the commissioner.

(5) The commissioner may refuse to issue a reinsurance intermediary license if, in his judgment, the applicant, anyone named on the application, or any

member, principal, officer or director of the applicant, is not trustworthy, or that any controlling person of such applicant is not trustworthy to act as a reinsurance intermediary, or that any of the foregoing has given cause for revocation or suspension of such license, or has failed to comply with any prerequisite for the issuance of such license. Upon written request therefor, the commissioner shall furnish a summary of the basis for refusal to issue a license.

(6) Licensed attorneys at law of this state when acting in their professional capacity as such shall be exempt from this section.

HISTORY: Laws, 1992, ch. 330, § 3, eff from and after July 1, 1992.

Cross References — Insurer not to engage unlicensed reinsurance intermediary broker, see § 83-19-211.

Reinsurer not to engage unlicensed reinsurance intermediary manager, see § 83-19-215.

RESEARCH REFERENCES

Am. Jur.

44A Am. Jur. 2d, Insurance §§ 1809-1825.

§ 83-19-207. Written authorization required for transactions between reinsurance intermediary broker and insurer; minimum contents of authorization.

Transactions between a reinsurance intermediary broker and the insurer it represents in such capacity shall only be entered into pursuant to a written authorization, specifying the responsibilities of each party. The authorization shall, at a minimum, contain provisions that:

(a) The insurer may terminate the reinsurance intermediary broker's authority at any time.

(b) The reinsurance intermediary broker shall render accounts to the insurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the reinsurance intermediary broker, and remit all funds due to the insurer within thirty (30) days of receipt.

(c) All funds collected for the insurer's account shall be held by the reinsurance intermediary broker in a fiduciary capacity in a bank which is a qualified U.S. financial institution as defined herein.

(d) The reinsurance intermediary broker shall comply with Section 83-19-209.

(e) The reinsurance intermediary broker shall comply with the written standards established by the insurer for the cession or retrocession of all risks.

(f) The reinsurance intermediary broker shall disclose to the insurer any relationship with any reinsurer to which business will be ceded or retroceded.

HISTORY: Laws, 1992, ch. 330, § 4, eff from and after July 1, 1992.

RESEARCH REFERENCES

Am. Jur.
44A Am. Jur. 2d, Insurance §§ 1809-1825.

§ 83-19-209. Records required to be kept by reinsurance intermediary broker; right of insurer to access, copy and audit records.

(1) For at least ten (10) years after expiration of each contract of reinsurance, the reinsurance intermediary broker shall keep a complete record for each transaction showing:

(a) The type of contract, limits, underwriting restrictions, classes or risks and territory;

(b) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation;

(c) Reporting and settlement requirements of balances;

(d) Rate used to compute the reinsurance premium;

(e) Names and addresses of assuming reinsurers;

(f) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary broker;

(g) Related correspondence and memoranda;

(h) Proof of placement;

(i) Details regarding retrocessions handled by the reinsurance intermediary broker, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(j) Financial records, including but not limited to, premium and loss accounts; and

(k) When the reinsurance intermediary broker procures a reinsurance contract on behalf of a licensed ceding insurer:

(i) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(ii) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

(2) The insurer shall have access and the right to copy and audit all accounts and records maintained by the reinsurance intermediary broker related to its business in a form usable by the insurer.

HISTORY: Laws, 1992, ch. 330, § 5, eff from and after July 1, 1992.

Cross References — Requirement that reinsurance intermediary broker comply with this section, see § 83-19-207.

§ 83-19-211. Required and prohibited acts of insurer with respect to reinsurance intermediary brokers.

(1) An insurer shall not engage the services of any person, firm, association or corporation to act as a reinsurance intermediary broker on its behalf unless such person is licensed as required by Section 83-19-205.

(2) An insurer may not employ an individual who is employed by a reinsurance intermediary broker with which it transacts business, unless such reinsurance intermediary broker is under common control with the insurer and subject to the Holding Company Act.

(3) The insurer shall obtain annually a copy of statements of the financial condition of each reinsurance intermediary broker with which it transacts business.

HISTORY: Laws, 1992, ch. 330, § 6, eff from and after July 1, 1992.

RESEARCH REFERENCES

Am. Jur.

44A Am. Jur. 2d, Insurance §§ 1809-1825.

§ 83-19-213. Written contract required for transactions between reinsurance intermediary manager and reinsurer; filing of contract; minimum contents of contract.

Transactions between a reinsurance intermediary manager and the reinsurer it represents in such capacity shall only be entered into pursuant to a written contract, specifying the responsibilities of each party, which shall be approved by the reinsurer's board of directors. At least thirty (30) days before such reinsurer assumes or cedes business through such producer, a true copy of the approved contract shall be filed with the commissioner for approval. The contract shall, at a minimum, contain provisions that:

(a) The reinsurer may terminate the contract for cause upon written notice to the reinsurance intermediary manager. The reinsurer may suspend the authority of the reinsurance intermediary manager to assume or cede business during the pendency of any dispute regarding the cause for termination.

(b) The reinsurance intermediary manager shall render accounts to the reinsurer accurately detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to the reinsurance intermediary manager, and remit all funds due under the contract to the reinsurer on not less than a monthly basis.

(c) All funds collected for the reinsurer's account will be held by the reinsurance intermediary manager in a fiduciary capacity in a bank which is a qualified United States financial institution as defined herein. The reinsurance intermediary manager may retain no more than three (3) months estimated claims payments and allocated loss adjustment expenses. The reinsurance intermediary manager shall maintain a separate bank account for each reinsurer that it represents.

(d) For at least ten (10) years after expiration of each contract of reinsurance, the reinsurance intermediary manager shall keep a complete record for each transaction showing:

(i) The type of contract, limits, underwriting restrictions, classes or risks and territory;

(ii) Period of coverage, including effective and expiration dates, cancellation provisions and notice required of cancellation, and disposition of outstanding reserves on covered risks;

(iii) Reporting and settlement requirements of balances;

(iv) Rate used to compute the reinsurance premium;

(v) Names and addresses of reinsurers;

(vi) Rates of all reinsurance commissions, including the commissions on any retrocessions handled by the reinsurance intermediary manager;

(vii) Related correspondence and memoranda;

(viii) Proof of placement;

(ix) Details regarding retrocessions handled by the reinsurance intermediary manager, as permitted by Section 83-19-217, including the identity of retrocessionaires and percentage of each contract assumed or ceded;

(x) Financial records, including but not limited to, premium and loss accounts; and

(xi) When the reinsurance intermediary manager places a reinsurance contract on behalf of a ceding insurer:

(A) Directly from any assuming reinsurer, written evidence that the assuming reinsurer has agreed to assume the risk; or

(B) If placed through a representative of the assuming reinsurer, other than an employee, written evidence that such reinsurer has delegated binding authority to the representative.

(e) The reinsurer will have access and the right to copy all accounts and records maintained by the reinsurance intermediary manager related to its business in a form usable by the reinsurer.

(f) The contract cannot be assigned in whole or in part by the reinsurance intermediary manager.

(g) The reinsurance intermediary manager shall comply with the written underwriting and rating standards established by the insurer for the acceptance, rejection or cession of all risks.

(h) Sets forth the rates, terms and purposes of commissions, charges and other fees which the reinsurance intermediary manager may levy against the reinsurer.

(i) If the contract permits the reinsurance intermediary manager to settle claims on behalf of the reinsurer:

(i) All claims will be reported to the reinsurer in a timely manner;

(ii) A copy of the claim file shall be sent to the reinsurer at its request or as soon as it becomes known that the claim:

(A) Has the potential to exceed the lesser of an amount determined by the commissioner or the limit set by the reinsurer;

(B) Involves a coverage dispute;

(C) May exceed the reinsurance intermediary manager's claims settlement authority;

(D) Is open for more than six (6) months; or

(E) Is closed by payment of the lesser of an amount set by the commissioner or an amount set by the reinsurer;

(iii) All claim files shall be the joint property of the reinsurer and reinsurance intermediary manager. However, upon an order of liquidation of the reinsurer such files shall become the sole property of the reinsurer or its estate; the reinsurance intermediary manager shall have reasonable access to and the right to copy the files on a timely basis;

(iv) Any settlement authority granted to the reinsurance intermediary manager may be terminated for cause upon the reinsurer's written notice to the reinsurance intermediary manager or upon the termination of the contract. The reinsurer may suspend the settlement authority during the pendency of the dispute regarding the cause of termination.

(j) If the contract provides for a sharing of interim profits by the reinsurance intermediary manager that such interim profits shall not be paid until one (1) year after the end of each underwriting period for property business and five (5) years after the end of each underwriting period for casualty business or a later period set by the commissioner for specified lines of insurance and not until the adequacy of reserves on remaining claims has been verified pursuant to Section 83-19-217(3).

(k) The reinsurance intermediary manager annually shall provide the reinsurer with a statement of its financial condition prepared by an independent certified accountant.

(*l*) The reinsurer shall periodically (at least semiannually) conduct an on-site review of the underwriting and claims processing operations of the reinsurance intermediary manager.

(m) The reinsurance intermediary manager shall disclose to the reinsurer any relationship it has with any insurer prior to ceding or assuming any business with such insurer pursuant to this contract.

(n) The acts of the reinsurance intermediary manager shall be deemed to be the acts of the reinsurer on whose behalf it is acting.

HISTORY: Laws, 1992, ch. 330, § 7, eff from and after July 1, 1992.

RESEARCH REFERENCES

Am. Jur.

44A Am. Jur. 2d, Insurance §§ 1809-1825.

§ 83-19-215. Prohibited acts of reinsurance intermediary manager.

The reinsurance intermediary manager shall not:

(a) Bind retrocessions on behalf of the reinsurer, except that the reinsurance intermediary manager may bind facultative retrocessions pursuant to obligatory facultative agreements if the contract with the reinsurer contains reinsurance underwriting guidelines for such retrocessions. Such guidelines shall include a list of reinsurers with which such automatic agreements are in effect, and for each such reinsurer, the coverages and amounts or percentages that may be reinsured, and commission schedules.

(b) Commit the reinsurer to participate in reinsurance syndicates.

(c) Appoint any producer without assuring that the producer is lawfully licensed to transact the type of reinsurance for which he is appointed.

(d) Without prior approval of the reinsurer, pay or commit the reinsurer to pay a claim, net of retrocessions, that exceeds the lesser of an amount specified by the reinsurer or one percent (1%) of the reinsurer's policyholder's surplus as of December 31 of the last complete calendar year.

(e) Collect any payment from a retrocessionaire or commit the reinsurer to any claim settlement with a retrocessionaire, without prior approval of the reinsurer. If prior approval is given, a report must be promptly forwarded to the reinsurer.

(f) Jointly employ an individual who is employed by the reinsurer.

(g) Appoint a sub-reinsurance intermediary manager.

HISTORY: Laws, 1992, ch. 330, § 8, eff from and after July 1, 1992.

RESEARCH REFERENCES

Am. Jur.

44A Am. Jur. 2d, Insurance §§ 1809-1825.

§ 83-19-217. Required and prohibited acts of reinsurer with respect to reinsurance intermediary managers.

(1) A reinsurer shall not engage the services of any person, firm, association or corporation to act as a reinsurance intermediary manager on its behalf unless such person is licensed as required by Section 83-19-205.

(2) The reinsurer shall annually obtain a copy of statements of the financial condition of each reinsurance intermediary manager which such reinsurer has engaged prepared by an independent certified accountant in a form acceptable to the commissioner.

(3) If a reinsurance intermediary manager establishes loss reserves, the reinsurer shall annually obtain the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred and outstanding on business produced by the reinsurance intermediary manager. This opinion shall be in addition to any other required loss reserve certification.

(4) Binding authority for all retrocessional contracts or participation in reinsurance syndicates shall rest with an officer of the reinsurer who shall not be affiliated with the reinsurance intermediary manager.

(5) Within thirty (30) days of termination of a contract with a reinsurance intermediary manager, the reinsurer shall provide written notification of such termination to the commissioner.

(6) A reinsurer shall not appoint to its board of directors, any officer, director, employee, controlling shareholder or subproducer of its reinsurance intermediary manager. This subsection shall not apply to relationships governed by the Holding Company Act or, if applicable, the Broker Controlled Insurer Act.

HISTORY: Laws, 1992, ch. 330, § 9, eff from and after July 1, 1992.

Cross References — Application of this section to payment of interim profits to reinsurance intermediary manager, see § 83-19-213.

RESEARCH REFERENCES

Am. Jur.
44A Am. Jur. 2d, Insurance §§ 1809-1825.

§ 83-19-219. Examination of reinsurance intermediary by commissioner; reinsurance intermediary manager examined as reinsurer; commissioner to adopt rules and regulations.

(1) A reinsurance intermediary shall be subject to examination by the commissioner. The commissioner shall have access to all books, bank accounts and records of the reinsurance intermediary in a form usable to the commissioner.

(2) A reinsurance intermediary manager may be examined as if it were the reinsurer.

(3) The commissioner may adopt reasonable rules and regulations for the implementation and administration of Sections 83-19-201 through 83-19-221.

HISTORY: Laws, 1992, ch. 330, § 10, eff from and after July 1, 1992.

RESEARCH REFERENCES

Am. Jur.
44A Am. Jur. 2d Insurance §§ 1809, 1814-1824.

§ 83-19-221. Penalties for violations of §§ 83-19-201 through 83-19-221.

(1) A reinsurance intermediary, insurer or reinsurer found by the com-

missioner, after a hearing conducted in accordance with Section 83-6-39, to be in violation of any provision(s) of Sections 83-19-201 through 83-19-221, shall:

(a) For each separate violation, pay a penalty in an amount not exceeding Five Thousand Dollars ($5,000.00);

(b) Be subject to revocation or suspension of its license; and

(c) If a violation was committed by the reinsurance intermediary, such reinsurance intermediary shall make restitution to the insurer, reinsurer, rehabilitator or liquidator of the insurer or reinsurer for the net losses incurred by the insurer or reinsurer attributable to such violation.

(2) The decision, determination or order of the commissioner pursuant to subsection (1) shall be subject to judicial review pursuant to Section 83-6-41.

(3) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided in the insurance law.

(4) Nothing contained in Sections 83-19-201 through 83-19-221 is intended to or shall in any manner limit or restrict the rights of policyholders, claimants, creditors or other third parties or confer any rights to such persons.

HISTORY: Laws, 1992, ch. 330, § 11, eff from and after July 1, 1992.

CHAPTER 20.

DOMICILE CHANGE FOR DOMESTIC AND FOREIGN INSURERS

Sec.
83-20-1. Foreign insurer becoming domestic insurer.
83-20-3. Transfer of domicile by domestic insurer.
83-20-5. Continuation of certificate of authority and other approvals.
83-20-7. Promulgation of rules and regulations by Commissioner of Insurance.

§ 83-20-1. Foreign insurer becoming domestic insurer.

Any insurer which is organized under the laws of any other state and is admitted to do business in this state for the purpose of writing insurance may become a domestic insurer by complying with all of the requirements of law relative to the organization and licensing of a domestic insurer of the same type and by designating its principal place of business at a place in this state. Such domestic insurer shall be entitled to like certificates and licenses to transact business in this state, and shall be subject to the authority and jurisdiction of this state.

HISTORY: Laws, 1989, ch. 352, § 1, eff from and after July 1, 1989.

§ 83-20-3. Transfer of domicile by domestic insurer.

Any domestic insurer may, upon the approval of the Commissioner of Insurance, transfer its domicile to any other state in which it is admitted to transact the business of insurance, and upon such a transfer shall cease to be a domestic insurer, and shall be admitted to this state if qualified as a foreign insurer. The Commissioner of Insurance shall approve any such proposed transfer unless he shall determine such transfer is not in the interest of the policyholders of this state.

HISTORY: Laws, 1989, ch. 352, § 2, eff from and after July 1, 1989.

§ 83-20-5. Continuation of certificate of authority and other approvals.

The certificate of authority, agents' appointments and licenses, rates, and other items which the Commissioner of Insurance allows, in his discretion, which are in existence at the time any insurer licensed to transact the business of insurance in this state transfers its corporate domicile to this or any other state by merger, consolidation or any other lawful method shall continue in full force and effect upon such transfer if such insurer remains duly qualified to transact the business of insurance in this state. All outstanding policies of any transferring insurer shall remain in full force and effect and need not be endorsed as to the new name of the company or its new location unless so ordered by the Commissioner of Insurance. Every transferring insurer shall file new policy forms with the Commissioner of Insurance on or before the effective date of the transfer, but may use existing policy forms with appropriate endorsements if allowed by, and under such conditions as approved by, the Commissioner of Insurance. However, every such transferring insurer shall notify the Commissioner of Insurance of the details of the proposed transfer, and shall file promptly, any resulting amendments to corporate documents filed or required to be filed with the Commissioner of Insurance.

HISTORY: Laws, 1989, ch. 352, § 3, eff from and after July 1, 1989.

§ 83-20-7. Promulgation of rules and regulations by Commissioner of Insurance.

The Commissioner of Insurance is hereby authorized to promulgate any rules and regulations in order to carry out the purposes of this chapter.

HISTORY: Laws, 1989, ch. 352, § 4, eff from and after July 1, 1989.

CHAPTER 21.

FOREIGN COMPANIES

General Provisions. 83-21-1
Unauthorized Insurers Process Law. 83-21-33

GENERAL PROVISIONS

Sec.

83-21-1. Certificate of authority; funding of agency expenses; deposit of monies into State General Fund.
83-21-3. Requirements for admission.
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83-21-18. Agreements with other states to establish procedures for allocation of premium taxes; definitions.
83-21-19. Resident and nonresident surplus lines insurance producers; licensing; fees; suspension, revocation or refusal of license; grounds; notice; hearing.
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83-21-25. Report of surplus lines insurance producer; "gross premiums"; designation of procuring surplus lines insurance producer to make report and payment; exemption from payment of surplus line premium tax on certain property risk.
83-21-27. Permissible acts of surplus lines insurance producers.
83-21-29. Suits against nonadmitted insurers.
83-21-31. Application of preceding and succeeding sections.

§ 83-21-1. Certificate of authority; funding of agency expenses; deposit of monies into State General Fund.

No foreign insurance, indemnity or guaranty company or other insurer shall be admitted and authorized to do business in this state until:

(a) It shall deposit with the Commissioner of Insurance a certified copy of its charter, articles of incorporation, bylaws or deed of settlement, and shall pay for the filing of such document the sum of One Thousand Dollars ($1,000.00) and a statement of its financial condition and business in such form and detail as he may require, signed and sworn to by its president and secretary or other proper officer.

(b) It shall satisfy the commissioner that it is fully and legally organized under the laws of its state or government to do the business it proposes to transact; and such capital or net assets are well invested and immediately available for the payment of losses in this state, and that it insures on any single hazard a sum no larger than one-tenth (1⁄10) of its net assets.

(c) It shall, by a duly executed instrument filed in his office, constitute and appoint the Commissioner of Insurance, and his successor, its true and lawful attorney, upon whom all process in any action or legal proceeding against it may be served, and therein shall agree that any process against it which may be served upon its attorney shall be of the same force and validity as if served on the company, and the authority thereof shall continue in force irrevocable so long as any liability of the company remains outstanding in this state. The service of such process shall be made by leaving a copy of the same in the hands or office of the commissioner. Copies of such instrument certified by the commissioner shall be deemed sufficient evidence thereof, and service upon such attorney shall be deemed sufficient service upon the principal.

(d) It shall appoint as its agent or agents in this state some resident or residents thereof, other than the commissioner; such appointment to be made in writing, signed by the president and secretary or manager or general agent, and filed in the office of the commissioner, authorizing the agent to acknowledge service of process for and on behalf of the company, consenting that service of process on the agent shall be as valid as if served upon the company, according to the laws of this state, and waiving all claims of error by reason of such service.

(e) It shall obtain from the commissioner a certificate that it has complied with the laws of the state and is authorized to make contracts of insurance.

(f) Such fees collected by the commissioner shall be deposited in the special fund in the State Treasury designated as the "Insurance Department Fund."

From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1906, § 2606; Hemingway's 1917, § 5069; 1930, § 5165; 1942, § 5672; Laws, 1977, ch. 326; Laws, 1977, ch. 395; Laws, 1982, ch. 391, § 1; Laws, 1988, ch. 526, § 7; Laws, 1991, ch. 429 § 1; Laws, 2003, ch. 347, § 1; Laws, 2016, ch. 459, § 32, eff from and after July 1, 2016.

Editor's Notes — Section 13 of ch. 526, Laws of 1988, provides as follows:
"SECTION 13. The commissioner may, after notice and hearing, issue rules and regulations that he deems necessary to effectuate the purposes of this act or to

eliminate devices or plans designed to avoid or render ineffective the provisions of this act. The commissioner may require such information as is reasonably necessary for the enforcement of this act. All rules and regulations adopted and promulgated pursuant to this act shall be subject to the provisions of the Mississippi Administrative Procedures Law as provided in Section 25-43-1 et seq. [now 25-43-1.101 et seq.], Mississippi Code of 1972."

Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Treatment, for income tax purposes, of interest earned by foreign insurance companies from loans secured by real estate in Mississippi, see § 27-7-23.

Mississippi insurance premium tax retaliatory law, see §§ 27-15-121 et seq.

Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Duty of commissioner before admitting foreign company, see § 83-1-23.

Examination of financial condition of foreign insurance company, see § 83-1-27.

Notification of foreign company of service of process upon commissioner, see § 83-5-11.

Regulation of sale of stock, see § 83-5-19.

Registration and examination of companies writing casualty insurance, ordinary life insurance or health and accident insurance, see §§ 83-6-1 et seq.

Merger or consolidation, or exchange of outstanding stock, of domestic and foreign stock insurance companies, see § 83-19-113.

For provisions relating to the change of domicile of a domestic or foreign insurer, see §§ 83-20-1 et seq.

Laws applicable to admitted foreign company, see § 83-21-7.

Admission of foreign fraternal society, see §§ 83-29-29 et seq.

Admission of foreign mutual company, see § 83-31-39.

Admission of foreign burial association, see § 83-37-7.

Legal expense insurance, see §§ 83-49-1 et seq.

Application of venue provisions of §§ 83-21-1 et seq. to legal expense insurance plan sponsors, see § 83-49-33.

For the rule controlling service of process on foreign companies, see Miss. Rule of Civil Proc. 4.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Appointment of insurance commissioner as attorney to receive service of process.
3. Appointment of agent upon whom process may be served.

1. In general.

Commissioner of Insurance is a statutory agent, rather than an agent in fact, under Miss. Code Ann. § 83-21-1(c) because foreign insurers are required to appoint the Commissioner as an agent; the linchpin for distinguishing agents in fact from statutory agents is not whether a statute requires the appointment, but whether the statute compels the appointment of a certain person, and an agent appointed under § 83-21-1(d) is an agent in fact because an insurer can choose the agent's identity. Burton v. Cont'l Cas. Co., 2006 U.S. Dist. LEXIS 79299 (S.D. Miss. Oct. 30, 2006).

Testimony of deputy chancery clerk that he had received statement from auditor held not proper proof of filing of charter, bylaws, rules, and regulations by the company. Supreme Ruling, F. M. C. v. Turner, 105 Miss. 468, 62 So. 497, 1913 Miss. LEXIS 232 (Miss. 1913).

Statutes liberally construed so as to include all organizations doing an insurance business of any kind. State v. Alley, 96 Miss. 720, 51 So. 467, 1910 Miss. LEXIS 183 (Miss. 1910).

2. Appointment of insurance commissioner as attorney to receive service of process.

Plaintiff's motion for reconsideration of an order denying his motion to remand to state court his suit against an insurer was denied; 28 U.S.C.S. § 1446's 30-day removal period did not begin running until the state insurance commissioner, who was a statutory agent that the insurer was required to appoint under Miss. Code Ann. § 83-21-1(c), gave the insurer a copy of the summons and complaint that had been served upon the commissioner, and because the insurer sought removal 29 days after receiving that notice, the motion to remove was timely. Burton v. Cont'l Cas. Co., 2006 U.S. Dist. LEXIS 79299 (S.D. Miss. Oct. 30, 2006).

In action by a buyer against a foreign insurer for damages for the value of an automobile and for the loss of its use, process issued by the circuit court clerk and served by the sheriff upon the insurance commissioner was insufficient to support a default judgment where the record failed to show that a certified copy of an instrument appointing the insurance commissioner as the insurer's true and lawful attorney was filed in the case. Motors Ins. Corp. v. Holland, 229 Miss. 262, 90 So. 2d 392, 1956 Miss. LEXIS 605 (Miss. 1956).

A statute calling for a foreign corporation residing outside the state to designate a person within the state as its agent for service of process in the state in return for the privilege of doing business within the state, is constitutional, and the designation of such agent is a voluntary act by which the corporation consents to be sued in the state; and such consent, when executed in conformity with valid state statute, extends to any court sitting in the state which applies the laws of the state, including federal courts, and therefore constitutes consent to be sued in federal court in the state and supplants the immunity conferred by rules governing venue. Neirbo Co. v. Bethlehem Shipbuilding Corp., 308 U.S. 165, 60 S. Ct. 153, 84 L. Ed. 167, 1939 U.S. LEXIS 77 (U.S. 1939).

The authorization by a foreign insurance company, conformably to this statute, of the state insurance commissioner as its attorney upon whom process may be served, which states that such authority may continue "so long as any liability of the company remains outstanding" in the state, does not extend to the acceptance of service of process in a suit brought by a nonresident upon a cause of action not arising in the state. Morris & Co. v. Skandinavia Ins. Co., 279 U.S. 405, 49 S. Ct. 360, 73 L. Ed. 762, 1929 U.S. LEXIS 329 (U.S. 1929).

If declaration against foreign indemnity company was required to set out appointment by company of insurance commissioner of state as company's process agent, such fact was sufficiently alleged in declaration which set out that foreign company was qualified to do business in state and "subject to the process of this court by service of summons" on insurance commissioner of Mississippi. Rawlings v. American Oil Co., 173 Miss. 683, 161 So. 851, 1935 Miss. LEXIS 236 (Miss. 1935).

In garnishment proceeding against bank's receiver by judgment creditor of foreign indemnity company, it would be conclusively presumed that court rendering judgment had before it necessary proof of appointment of state insurance commissioner as company's process agent, where judgment recited that defendants were legally served with personal process, and return on process in record showed service on insurance commissioner as process agent for company. Rawlings v. American Oil Co., 173 Miss. 683, 161 So. 851, 1935 Miss. LEXIS 236 (Miss. 1935).

Certified copy of appointment of state insurance commissioner as agent for foreign insurance corporation for service of process held sufficient proof of such fact as basis for service of writ of garnishment. Universal Life Ins. Co. v. Catchings, 169 Miss. 26, 152 So. 817, 1934 Miss. LEXIS 23 (Miss. 1934).

Word "liability," within statute authorizing appointment of state insurance commissioner as agent of foreign insurance corporation for service of process, held not confined to contracts along, but to any liability cognizable in courts. Universal Life Ins. Co. v. Catchings, 169 Miss. 26, 152 So. 817, 1934 Miss. LEXIS 23 (Miss. 1934).

Appointment of state insurance commissioner as agent of foreign insurance corporation for service of process cannot be revoked as long as there is any outstanding liability against insurance corporation in state. Universal Life Ins. Co. v. Catchings, 169 Miss. 26, 152 So. 817, 1934 Miss. LEXIS 23 (Miss. 1934).

Statute requiring foreign insurance companies to appoint insurance commissioner as agent for service of process does not subject such insurance companies to jurisdiction of state courts in controversies growing out of transactions wholly without state. Morris & Co. v. Skandinavia Ins. Co., 161 Miss. 411, 137 So. 110, 1931 Miss. LEXIS 271 (Miss. 1931).

The authorization by a foreign insurance company, conformably to this statute, of the state insurance commissioner as its attorney upon whom process may be served, which states that such authority may continue "so long as any liability of the company remains outstanding" in the state, does not extend to the acceptance of service of process in a suit brought by a nonresident upon a cause of action not arising in the state. Morris & Co. v. Skandinavia Ins. Co., 279 U.S. 405, 49 S. Ct. 360, 73 L. Ed. 762, 1929 U.S. LEXIS 329 (U.S. 1929).

Mere showing of service of summons on state insurance commissioner held insufficient to authorize default judgment against foreign insurance company. Globe Rutgers Fire Ins. Co. v. Sayle, 107 Miss. 169, 65 So. 125, 1914 Miss. LEXIS 68 (Miss. 1914); Continental Casualty Co. v. Gilmer, 146 Miss. 22, 111 So. 741, 1927 Miss. LEXIS 213 (Miss. 1927).

Clerk need not mail copy of summons to foreign insurance company where insurance commissioner was served as its attorney in fact. Fidelity & Casualty Co. v. Cross, 127 Miss. 31, 89 So. 780, 1921 Miss. LEXIS 198 (Miss. 1921).

Court cannot take judicial notice of appointment of insurance commissioner as agent for process by his acceptance of service. Globe Rutgers Fire Ins. Co. v. Sayle, 107 Miss. 169, 65 So. 125, 1914 Miss. LEXIS 68 (Miss. 1914).

Appointment of insurance commissioner as agent for service of process can be proved only by certified copy thereof. Globe Rutgers Fire Ins. Co. v. Sayle, 107 Miss. 169, 65 So. 125, 1914 Miss. LEXIS 68 (Miss. 1914).

3. Appointment of agent upon whom process may be served.

Jurisdiction of foreign insurance company cannot be obtained by service on former agent who is not in fact agent of company when process is served. Fireman's Fund Ins. Co. v. Cole, 169 Miss. 634, 152 So. 872, 1934 Miss. LEXIS 40 (Miss. 1934).

Statute providing for substituted service on foreign corporation does not apply to suits against insurance companies appointing agents for service of process. Great Southern Life Ins. Co. v. Gomillion, 145 Miss. 314, 110 So. 770, 1927 Miss. LEXIS 116 (Miss. 1927).

Return of process served on duly appointed agent of insurance company may be amended during next sitting term without service of copy of motion to amend. Great Southern Life Ins. Co. v. Gomillion, 145 Miss. 314, 110 So. 770, 1927 Miss. LEXIS 116 (Miss. 1927).

RESEARCH REFERENCES

ALR.

Theory of waiver as applicable where provisions of policy or acts of insurer are inconsistent with statutory requirements. 9 A.L.R.2d 1436.

Construction, application, and operation of state "retaliatory" statutes imposing special taxes or fees on foreign insurers doing business with the state. 30 A.L.R.4th 873.

Duty of liability insurer to initiate settlement negotiations. 51 A.L.R.5th 701.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 85, 86.

14 Am. Jur. Pl & Forms (Rev), Insur-

ance, Form No. 22 (petition or application for writ of mandamus to compel issuance of license to foreign corporation to conduct insurance business within state).

CJS.

44 C.J.S., Insurance §§ 129, 130.

Practice References.

Business Law Monographs (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-21-3. Requirements for admission.

(1)(a) No foreign insurance company, association, or other insurance entity, either stock, mutual, or reciprocal, shall be admitted to do business or granted a certificate of authority or license to do business in this state unless and until such company or association shall have done business for a period of at least two (2) years in the state of its domicile, or unless such company seeking admission is the subsidiary or affiliate of a company already licensed in Mississippi.

(b) The Commissioner of Insurance may waive this requirement upon a written request by the applicant and a finding that the applicant meets the following criteria:

(i) The company provides a service that is considered underserved in the state;

(ii) The company has adequate capital and surplus; and

(iii) The company possesses significant management and business experience in its respective line of business.

(2) No foreign stock insurance company shall be admitted or granted a certificate of authority or license to do business in this state unless its paid-up capital stock and its surplus at the time of licensing or renewal of license shall be equal to that required for the organization or incorporation of a like domestic company under the laws of this state.

(3) No foreign mutual or reciprocal insurance company or association shall be admitted or granted a certificate of authority or license to do business in this state unless, at the time of licensing or renewal of license, its surplus shall be equal to that required by the laws of this state for the organization or formation of a like domestic insurance company or association.

(4) No foreign stock, mutual, or reciprocal insurance company or association, incorporated or organized under the laws of any state of the United States, shall be admitted to do business, or granted a certificate of authority, or have license therefor renewed until such company shall have deposited with the State Treasurer of this state securities in an amount not less than Fifty Thousand Dollars ($50,000.00). Securities deposited in accordance with this section shall be classified as admitted assets for the purpose of determining eligibility of such securities. Provided, however, any company maintaining a deposit with the insurance regulatory authority or any other designated public official of its state of domicile, or of any other state, in trust for the benefit of all its policyholders, or policyholders and creditors, may be exempt from the deposit herein provided upon such company delivering to the Commissioner of Insurance a certificate to such effect, duly authenticated by the appropriate

state official holding such deposit. The commissioner may require in addition to the certification of deposit by the public official of its state of domicile an amount not less than Fifty Thousand Dollars ($50,000.00) be deposited with the State Treasurer of this state. Any deposit made in this state under the provisions of this section shall be for the exclusive use and benefit of policyholders, or policyholders and creditors, in this state; and such deposit shall not bar claim to other assets of the company by policyholders, or policyholders and creditors, in this state in the event of insolvency, receivership, or liquidation of the company.

Notwithstanding any other provision of law, the securities eligible for deposit under the insurance laws of this state relating to deposit of securities by an insurance company as a condition of commencing or continuing to do an insurance business in this state may be deposited with a clearing corporation or held in the Federal Reserve book-entry system. Securities deposited with a clearing corporation or held in the Federal Reserve book-entry system and used to meet the deposit requirements under the insurance laws of this state shall be under the control of the Commissioner of Insurance and shall not be withdrawn by the insurance company without the approval of Commissioner of Insurance. Any insurance company holding securities in such manner shall provide to the Commissioner of Insurance evidence issued by its custodian or member bank through which such insurance company has deposited such securities in a clearing corporation or through which such securities are held in the Federal Reserve book-entry system, respectively, in order to establish that the securities are actually recorded in an account in the name of the custodian or other direct participant or member bank, and that the records of the custodian, other participant or member bank reflect that such securities are held subject to the order of the Commissioner of Insurance.

(5) In case any insurer which has made a deposit with the Commissioner of Insurance, or other designated official or custodian in this state, of cash or securities in trust for the protection of its policyholders or creditors or both in this state, or of its policyholders or creditors or both in the United States, thereafter becomes merged or consolidated in accordance with the laws of this state if a domestic insurer, or in accordance with the laws of its domiciliary state or nation if a foreign or alien insurer, and upon the effectuation of the merger or consolidation, the resulting corporation is or becomes authorized to do business in this state, the commissioner, or other designated official or custodian, as the case may be, upon the resulting corporation's being so authorized, shall release and transfer the cash or securities so deposited by the merged or consolidated insurer to the resulting corporation, or to such person as it may designate to take and receive the same.

If any insurer which has made such a deposit with the Commissioner of Insurance or other designated official or custodian in the state hereafter withdraws from and ceases to do business in this state, and has paid or provided for the payment of all its obligations and liabilities to its policyholders and creditors in this state by the assumption or reinsurance of the same by an insurer which is or becomes authorized to transact business in this state, the

Commissioner of Insurance or other designated official or custodian, as the case may be, shall release and transfer the cash or securities constituting its deposit to such withdrawing insurer, or to such person as it may designate to take and receive the same.

Any release or transfer pursuant hereto shall be made upon application to and the written order of the Commissioner of Insurance. Neither the Commissioner of Insurance, nor other designated official or custodian, as the case may be, shall have any liability for the release or transfer of any such deposit made or authorized in good faith.

HISTORY: Codes, 1942, § 5677.5; Laws, 1956, ch. 333, §§ 1-3; Laws, 1958, ch. 442, § 1; Laws, 1962, ch. 462, § 1; Laws, 1991, ch. 420 § 1; Laws, 2001, ch. 412, § 6; Laws, 2013, ch. 459, § 19, eff from and after July 1, 2013.

Cross References — Acceptability of farm credit securities for deposit, see § 75-69-7.

Provisions relating to paid-up capital stock and surplus requirements for domestic stock insurance companies, see § 83-19-31.

For provisions relating to the change of domicile of a domestic or foreign insurer, see §§ 83-20-1 et seq.

Revocation of license for deficiency in capital, surplus, or reserves, see § 83-21-13.

Surety companies to possess capital and surplus requirements as required in this section and § 83-19-31, see § 83-27-1.

Utilization of modern systems such as clearing corporations and the Federal Reserve book-entry system for the deposit of securities without physical delivery, see §§ 83-67-1 et seq.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance §§ 85, 86.	44 C.J.S., Insurance §§ 132, 133.

§ 83-21-5. Deposit required for companies outside United States.

No foreign company, if incorporated or organized under the laws of any government or state elsewhere than in the United States, shall be admitted until it has made a deposit with the treasurer of the state, or with the financial officer of some other states of the United States, of a sum not less than the capital required of like companies under this chapter. Such deposit must be in exclusive trust for the benefit and security of all the company's policyholders and creditors in the United States, and such deposit shall be deemed for all purposes of the insurance law the capital of the company making it.

HISTORY: Codes, 1906, § 2610; Hemingway's 1917, § 5073; 1930, § 5166; 1942, § 5676.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 85.	44 C.J.S., Insurance §§ 132, 133.

§ 83-21-7. Applicable laws.

Foreign insurance companies, upon complying with the conditions applicable to such companies, may be admitted to transact in this state, by constituted agents resident therein, any class of insurance authorized by the laws now or hereafter in force relative to the duties, obligations, prohibitions, and penalties of insurance companies, and shall be subject to all laws applicable to the transaction of such business by foreign insurance companies and their agents. No provision of law which by its terms applies specifically to domestic life insurance companies shall thereby become applicable to foreign life insurance companies; and in the case of life insurance companies, the residence requirement shall not apply to agents who are residents of other states which permit residents of Mississippi to be licensed therein.

HISTORY: Codes, 1892, § 2340; 1906, § 2605; Hemingway's 1917, § 5068; 1930, § 5167; 1942, § 5677; Laws, 1928, ch. 23.

Cross References — Laws applicable to domestic insurance companies, see § 83-5-13.

Laws applicable to nonadmitted insurer, see § 83-21-17.

Laws applicable to mutual companies, see § 83-31-37.

JUDICIAL DECISIONS

1. In general.

Under the 14th amendment of the Federal Constitution, a foreign insurance company which has not complied with the laws prescribing how such companies may do business in this state cannot be denied the right to sue in the courts of this state to collect premium on a policy written in the state of the company's domicile. Swing v. B. E. Brister & Co., 87 Miss. 516, 40 So. 146, 1905 Miss. LEXIS 181 (Miss. 1905).

Policy of insurance on property in this state written through a broker of another state in a foreign company was not a Mississippi contract, and not void because the insurer had not complied with the laws of this state. Swing v. B. E. Brister & Co., 87 Miss. 516, 40 So. 146, 1905 Miss. LEXIS 181 (Miss. 1905).

Suit to collect premiums on such policies is not transacting the business of insurance in this state. Swing v. B. E. Brister & Co., 87 Miss. 516, 40 So. 146, 1905 Miss. LEXIS 181 (Miss. 1905).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 79 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 41 (complaint or declaration by state against foreign insurance company for forfeiture of licenses-formation of monopoly through underwriters' association).

CJS.

44 C.J.S., Insurance § 127.

§ 83-21-9. License refused on certain conditions.

When an insurance company organized under the laws of any state or country is prohibited by the laws of said state or country or by its charter from investing its assets other than capital stock in the bonds of this state, then and in such case the commissioner of insurance is authorized and directed to refuse to grant a license to transact business in Mississippi to such insurance company.

HISTORY: Codes, 1906, § 2617; Hemingway's 1917, § 5080; 1930, § 5168; 1942, § 5678.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 85.

CJS.
44 C.J.S., Insurance §§ 129, 130.

§ 83-21-11. Repealed.

Repealed by Laws, 1997, ch. 410, § 25, eff from and after July 1, 1997.

§ 83-21-11. [Codes, 1906, § 2667; Hemingway's 1917, § 5133; 1930, § 5169; 1942, § 5679]

Editor's Notes — Former § 83-21-11 provided for the revocation of insurance licenses of foreign insurance companies under certain conditions.

§ 83-21-13. Revocation of license for deficiency in capital, surplus, or reserves.

Any company heretofore licensed shall have its financial status reviewed upon the filing of its annual statement, and in the event of a deficiency in either capital, surplus, or reserves, the license of the company and the certificate of authority of its agents to represent said company shall be immediately revoked.

HISTORY: Codes, 1942, § 5679.5; Laws, 1958, ch. 442, § 2.

Cross References — Application of this section to suspension, revocation or refusal of license for failure to submit to examination by commissioner, see § 83-5-207.

Capital and surplus requirements for admission, see § 83-21-3.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 87.
14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.
44 C.J.S., Insurance §§ 129, 130.

§ 83-21-15. Repealed.

Repealed by Laws, 2001, ch. 510, § 34, eff from and after January 1, 2002.

§ 83-21-15. [Codes, 1942, § 5674; Laws, 1942, ch. 271; Laws, 1948, ch. 347; Laws, 1956, ch. 338, §§ 1-10; Laws, 1994, ch. 385, § 1; Laws, 1995, ch. 361, § 2; Laws, 1996, ch. 319, § 1; Laws, 1999, ch. 345, § 1; Laws, 2001, ch. 376, § 1.]

Editor's Notes — Former § 83-21-15 was entitled "Non-resident brokers or agents."

§ 83-21-17. Nonadmitted insurers.

(1) The Commissioner of Insurance shall annually promulgate a list of nonadmitted insurers found eligible for writing business in the State of Mississippi, provided each such insurer qualifies under one (1) of the following paragraphs:

(a) Has capital and surplus or its equivalent under the laws of its domiciliary jurisdiction which is the greater of:

(i) The same requirements as to capital and surplus as is required of a company licensed to do business in the State of Mississippi; or

(ii) Fifteen Million Dollars ($15,000,000.00).

(b) The requirements of paragraph (a) of this subsection may be satisfied by an insurer's possessing of less than the minimum capital and surplus upon an affirmative finding of acceptability by the commissioner. The finding shall be based upon such factors as quality of management, capital and surplus of any parent company, company underwriting profit and investment income trends, market availability and company record and reputation within the industry. In no event shall the commissioner make an affirmative finding of acceptability when the nonadmitted insurer's capital and surplus is less than Four Million Five Hundred Thousand Dollars ($4,500,000.00).

(c) In the case of a Lloyd's plan or other similar group of insurers, which consists of unincorporated individual insurers, or a combination of both incorporated and unincorporated insurers:

(i) The plan or group maintains a trust fund that shall consist of a trusteed account representing the group's liabilities attributable to business written in the United States;

(ii) In addition, the group shall establish and maintain in trust a surplus in the amount of One Hundred Million Dollars ($100,000,000.00), which shall be available for the benefit of United States surplus lines policyholders of any member of the group;

(iii) The incorporated members of the group shall not be engaged in any business other than underwriting as a member of the group and shall be subject to the same level of solvency regulation and control by the group's domiciliary regulator as are the unincorporated members; and

(iv) The trust funds shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, consisting of cash, securities, letters of credit or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state and, in addition, the trust required by subparagraph (ii) of this paragraph shall satisfy the requirements of the Standard Trust Agreement required for listing with the National Association of Insurance Commissioners' (NAIC) International Insurers Department.

(d) In the case of a group of incorporated insurers under common administration, which has continuously transacted an insurance business outside the United States for at least three (3) years immediately prior to this time, and which submits to this state's authority to examine its books and records and bears the expense of the examination:

(i) The group shall maintain an aggregate policyholders' surplus of Ten Billion Dollars ($10,000,000,000.00); and

(ii) The group shall maintain in trust a surplus in the amount of One Hundred Million Dollars ($100,000,000.00), which shall be available for the benefit of United States surplus lines policyholders of any member of the group; and

(iii) Each insurer shall individually maintain capital and surplus of not less than Twenty-five Million Dollars ($25,000,000.00) per company; and

(iv) The trust funds shall satisfy the requirements of the Standard Trust Agreement requirement for listing with the NAIC's International Insurers Department, and shall be maintained in an irrevocable trust account in the United States in a qualified financial institution, and shall consist of cash, securities, letters of credit or investments of substantially the same character and quality as those which are eligible investments for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state; and

(v) Additionally, each member of the group shall make available to the commissioner an annual certification of the member's solvency by the member's domiciliary regulator and its independent public accountant.

(e) Except for a plan complying with paragraphs (c) or (d) of this subsection, an insurer not domiciled in one (1) of the United States or its territories shall satisfy the capital and surplus requirements of paragraph (a) and shall have in force a trust fund of not less than the greater of:

(i) Five Million Four Hundred Thousand Dollars ($5,400,000.00); or

(ii) Thirty percent (30%) of the United States surplus lines gross liabilities, excluding aviation, wet marine and transportation insurance liabilities, not to exceed Sixty Million Dollars ($60,000,000.00) to be determined annually on the basis of accounting practices and procedures substantially equivalent to those promulgated by this state, as of December 31 next preceding the date of determination, where:

1. The liabilities are maintained in an irrevocable trust account in the United States in a qualified financial institution, on behalf of United States policyholders consisting of cash, securities, letters of credit or other investments of substantially the same character and quality as those which are eligible investments under Section 83-19-51 for the capital and statutory reserves of admitted insurers to write like kinds of insurance in this state. The trust fund, which shall be included in any calculation of capital and surplus or its equivalent, shall satisfy the requirements of the Standard Trust Agreement required for listing with the NAIC's International Insurers Department; and

2. The insurer may request approval from the commissioner to use the trust fund to pay valid surplus lines claims; provided, however, that

the balance of the trust fund is never less than the greater of Five Million Four Hundred Thousand Dollars ($5,400,000.00) or thirty percent (30%) of the insurer's current gross United States surplus lines liabilities, excluding aviation, wet marine and transportation insurance liabilities; and

3. In calculating the trust fund amount required by this subsection, credit shall be given for surplus lines deposits separately required and maintained for a particular state or United States territory, not to exceed the amount of the insurer's loss and loss adjustment reserves in the particular state or territory.

(f) An insurer or group of insurers meeting the requirements to do a surplus lines business in this state on March 11, 2011, shall have two (2) years from March 11, 2011, to meet the requirements of paragraph (e) of this subsection as follows:

Year Following March 11, 2011	**Trust Fund Requirement**
1	Fifteen percent (15%) of U.S. surplus lines liabilities, excluding aviation, wet marine and transportation insurance, with a maximum of Thirty Million Dollars
2	Thirty percent (30%) of U.S. surplus lines liabilities, excluding aviation, wet marine and transportation insurance, with a maximum of Sixty Million Dollars ($60,000,000.00)

(g) The commissioner shall have the authority to adjust, in response to inflation, the trust fund amounts required by paragraph (e) of this subsection.

(h) An alien insurer shall be listed with the Quarterly Listing of Alien Insurers maintained by the International Insurers Department of the National Association of Insurance Commissioners.

(2) The Commissioner of Insurance is specifically vested with authority to promulgate such rules and regulations as deemed necessary to carry out the provisions hereof.

(3) The commissioner shall publish a list of nonadmitted insurers found eligible for writing business in the State of Mississippi on a nonadmitted basis. The commissioner may, by giving seven (7) days' notice, at any time remove a nonadmitted insurer from such eligible list when it appears that such insurer no longer meets the requirements of the statute or regulations of the commissioner. When a nonadmitted insurer is placed upon or removed from the eligible list, all surplus lines insurance producers holding licenses under Sections 83-21-17 through 83-21-31 shall be notified of such eligibility or removal.

(4) Each nonadmitted insurer shall annually pay a filing fee of Five Hundred Dollars ($500.00) in order to be eligible for certification as a nonadmitted insurer.

(5)(a) Each insured in this state who directly procures or renews insurance with a nonadmitted insurer on properties, risks or exposures located or to be performed, in whole or in part, in this state, other than insurance procured through a surplus lines licensee, shall, within thirty (30) days after the date the insurance was so procured or renewed, file a written report with the commissioner, upon forms prescribed by the commissioner, showing the name and address of the insured or insureds, name and address of the insurer, the subject of the insurance, a general description of the coverage, the amount of premium currently charged, and additional pertinent information reasonably requested by the commissioner.

(b) Gross premiums charged for the independently procured insurance, less any return premiums, are subject to the same premium tax rate as set forth in Section 83-21-25. At the time of filing the report required in paragraph (a) of this subsection (5), the insured shall pay the tax to the commissioner.

HISTORY: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; 1942, § 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1988, ch. 526, § 8; Laws, 1991, ch. 353 § 1; Laws, 1994, ch. 333, § 2; Laws, 2011, ch. 380, § 1, eff from and after passage (approved Mar. 11, 2011).

Editor's Notes — Laws of 1988, ch. 526, § 13, provides as follows:

"SECTION 13. The commissioner may, after notice and hearing, issue rules and regulations that he deems necessary to effectuate the purposes of this act or to eliminate devices or plans designed to avoid or render ineffective the provisions of this act. The commissioner may require such information as is reasonably necessary for the enforcement of this act. All rules and regulations adopted and promulgated pursuant to this act shall be subject to the provisions of the Mississippi Administrative Procedures Law as provided in Section 25-43-1 et seq. [now Section 25-43-1.101 et seq.], Mississippi Code of 1972."

Cross References — Revocation of license of fire and casualty insurance agents, see § 83-17-13.

Capital and surplus requirements for admission, see § 83-21-3.

Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

JUDICIAL DECISIONS

1. In general.

A nonadmitted insurer was not liable to its former insured where the insurer had required that reinstatement of lapsed insurance policies could only be made by payment of the premiums to it at its home office in Alabama but the former insured had instead made payments of the premiums to a local, Mississippi insurance agent. Pasco Enterprises, Inc. v. Southland Ins. Agency, Inc., 408 So. 2d 63, 1981 Miss. LEXIS 2433 (Miss. 1981).

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 80.	44 C.J.S., Insurance § 125.

§ 83-21-18. Agreements with other states to establish procedures for allocation of premium taxes; definitions.

(1) The Commissioner of Insurance may enter into an agreement, compact, or otherwise establish procedures to allocate among the states the premium taxes paid to an insured's home state according to the Nonadmitted and Reinsurance Reform Act of 2010 (NRRA), which was incorporated intact into the Dodd-Frank Financial Reform Bill, H.R. 4173, which provides that only an insured's "home state" may require a premium tax payment for nonadmitted insurance, and that the placement of all nonadmitted insurance shall be subject solely to the statutory and regulatory requirements imposed by the insured's "home state."

(a) The agreement, compact, or procedures may provide for the adoption of nationwide uniform requirements, forms and procedures which provide for the reporting, payment, collection and allocation of premium taxes for nonadmitted insurance consistent with the NRRA.

(b) This agreement may allow the commissioner to collect and disburse to reciprocal states any funds collected under a policy that may be allocated to another reciprocal state where the insurance covers properties, risks or exposures located or to be performed both in and out of this state. The sum payable may include the amount of gross premiums and fees allocated to this state, plus an amount equal to the portion of premium and fees allocated to other states or territories, on the basis of the tax rates and fees applicable to properties, risks or exposures located or to be performed outside of this state. To the extent that other states where portions of the properties, risks or exposures reside have failed to enter into a compact or reciprocal allocation procedures with this state, the net premium tax may be retained by this state.

(c) The commissioner is authorized to enter into a cooperative agreement or interstate agreement or compact to establish additional and alternative nationwide uniform eligibility requirements that shall be applicable to nonadmitted insurers domiciled in another state or territory of the United States.

(2) For the purposes of this chapter, the following definitions shall apply:

(a) "Home state" means:

(i) In general, except as provided in subparagraph (ii), the term "home state" means, with respect to an insured:

1. The state in which an insured maintains its principal place of business or, in the case of an individual, the individual's principal residence; or

2. If one hundred percent (100%) of the insured risk is located outside the state referred to in item 1 of this subparagraph (i), the state

to which the greatest percentage of the insured's taxable premium for that insurance contract is allocated.

(ii) If more than one (1) insured from an affiliated group are named insureds on a single nonadmitted insurance contract, the term "home state" means the home state, as determined according to subparagraph (i)1 of this paragraph (a), of the member of the affiliated group that has the largest percentage of premium attributed to it under such insurance contract.

(b) "Independently procured insurance" means any property and casualty insurance permitted in a state to be placed directly with a nonadmitted insurer eligible to accept such business.

(c) "Multistate risk" means a risk covered by a nonadmitted insurer with insured exposures in more than one (1) state.

(d) "Nonadmitted insurance" means any property and casualty insurance permitted in a state to be placed directly or through a surplus lines insurance producer with a nonadmitted insurer eligible to accept such insurance.

(e) "Principal place of business" means, with respect to determining the home state of the insured, the state where the insured maintains its headquarters and where the insured's high-level officers direct, control and coordinate the business activities.

(f) "Principal residence" means, with respect to determining the home state of the individual, the state where the individual resides for the greatest number of days during a calendar year.

(g) "Single-state risk" means a risk covered by a nonadmitted insurer with insured exposures in only one (1) state.

(h) "Surplus lines insurance" means any property and casualty insurance permitted in a state to be placed through a surplus lines insurance producer with a nonadmitted insurer eligible to accept such insurance.

(i) "Surplus lines insurance producer" means an individual who is licensed in this state to sell, solicit or negotiate insurance on properties, risks or exposures located or to be performed in this state with nonadmitted insurers.

(3) The provisions set forth in Sections 83-21-19 through 83-21-27 shall only apply if Mississippi is the home state as defined herein.

HISTORY: Laws, 2011, ch. 380, § 2, eff from and after passage (approved Mar. 11, 2011).

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in (2)(a)(ii). The word "has" was inserted between the words "that" and "the" in following excerpt "...a member of the affiliated group that the largest percentage. . ." so the phrase now reads "a member of the affiliated group that has the largest percentage. . ." The Joint Committee ratified the correction at its July 13, 2011, meeting.

Federal Aspects — Nonadmiteed and Reinsurance Reform Act of 2010, see 15 USCS § 8201 et seq. Dodd-Frank Wall Street Reform and Consumer Protection Act, P.L. 111-203, 124 Stat. 1376.

§ 83-21-19. Resident and nonresident surplus lines insurance producers; licensing; fees; suspension, revocation or refusal of license; grounds; notice; hearing.

(1) Surplus lines insurance may be placed by a surplus lines insurance producer if:

(a) Each insurer is an eligible surplus lines insurer;

(b) Each insurer is authorized to write the line of insurance in its domiciliary jurisdiction; and

(c) All other requirements as set forth by law are met.

(2) The Commissioner of Insurance, upon the biennial payment of a fee of One Hundred Dollars ($100.00) and submission of a completed license application on a form approved by the commissioner, may issue a surplus lines insurance producer license to a qualified holder of an insurance producer license with a property, casualty and/or personal lines line of authority, who is regularly commissioned to represent a fire and casualty insurance company licensed to do business in the state.

(3) The privilege license shall continue from the date of issuance until the last day of the month of the licensee's birthday in the second year following issuance or renewal of the license, with a minimum term of twelve (12) months.

(4) A nonresident person shall receive a surplus lines insurance producer license if:

(a) The person is currently licensed as a surplus lines insurance producer or equivalent and in good standing in his or her home state;

(b) The person has submitted the proper request for licensure and has paid the biennial fee of One Hundred Dollars ($100.00); and

(c) The person's home state awards nonresident surplus lines licenses to residents of this state on the same basis.

(5) The commissioner may verify a person's licensing status through the National Producer Database maintained by the National Association of Insurance Commissioners, its affiliates or subsidiaries.

(6) A nonresident surplus lines insurance producer licensee who moves from one (1) state to another state, or a resident surplus lines licensee who moves from this state to another state, shall file a change of address and provide certification from the new resident state within thirty (30) days of the change of legal residence. No fee or license application is required.

(7) The commissioner may deny, suspend, revoke or refuse the license of a surplus lines insurance producer licensee and/or levy a civil penalty in an amount not to exceed Two Thousand Five Hundred Dollars ($2,500.00) per violation, after notice and hearing as provided hereunder, for one or more of the following grounds:

(a) Providing incorrect, misleading, incomplete or materially untrue information in the license application;

(b) Violating any insurance laws, or violating any regulation, subpoena or order of the commissioner or of another state's commissioner;

(c) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(d) Improperly withholding, misappropriating or converting any monies or properties received in the course of doing the business of insurance;

(e) Intentionally misrepresenting the terms of an actual or proposed insurance contract or application for insurance;

(f) Having been convicted of a felony;

(g) Having admitted or been found to have committed any insurance unfair trade practice or fraud;

(h) Using fraudulent, coercive or dishonest practices or demonstrating incompetence, untrustworthiness or financial irresponsibility in the conduct of business in this state or elsewhere;

(i) Having an insurance producer license, or its equivalent, denied, suspended or revoked in any other state, province, district or territory;

(j) Forging another's name to an application for insurance or to any document related to an insurance transaction;

(k) Improperly using notes or any other reference material to complete an examination for an insurance license;

(*l*) Knowingly accepting insurance business from an individual who is not licensed;

(m) Failing to comply with an administrative or court order imposing a child support obligation; or

(n) Failing to pay state income tax or comply with any administrative or court order directing payment of state income tax.

(8) If the action by the commissioner is to nonrenew, suspend, revoke or to deny an application for a license, the commissioner shall notify the applicant or licensee and advise, in writing, the applicant or licensee of the reason for the denial or nonrenewal of the applicant's or licensee's license. The applicant or licensee may make written demand upon the commissioner within ten (10) days for a hearing before the commissioner to determine the reasonableness of the commissioner's action. The hearing shall be held within thirty (30) days.

(9) Every surplus lines insurance contract procured and delivered according to Sections 83-21-17 through 83-21-31 shall have stamped upon it in bold ten-point type, and bear the name of the surplus lines insurance producer who procured it, the following: "NOTE: This insurance policy is issued pursuant to Mississippi law covering surplus lines insurance. The company issuing the policy is not licensed by the State of Mississippi, but is authorized to do business in Mississippi as a nonadmitted company. The policy is not protected by the Mississippi Insurance Guaranty Association in the event of the insurer's insolvency." No diminution of the license fee herein provided shall occur as to any license effective after January 1 of any year.

HISTORY: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; 1942, § 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1977, ch. 397; Laws, 1988, ch. 526, § 9; Laws, 2000, ch. 606, § 1; Laws, 2009, ch. 448, § 13; Laws, 2011, ch. 380, § 3; Laws, 2017, ch. 339, § 1, eff from and after July 1, 2017.

Editor's Notes — Section 13 of ch. 526, Laws of 1988, provides as follows:

"SECTION 13. The commissioner may, after notice and hearing, issue rules and regulations that he deems necessary to effectuate the purposes of this act or to eliminate devices or plans designed to avoid or render ineffective the provisions of this act. The commissioner may require such information as is reasonably necessary for the enforcement of this act. All rules and regulations adopted and promulgated pursuant to this act shall be subject to the provisions of the Mississippi Administrative Procedures Law as provided in Section 25-43-1 et seq. [now 25-43-1.101 et seq.], Mississippi Code of 1972."

Cross References — Licensing of agents generally, see § 83-17-5.

Provisions of §§ 83-21-19 through 83-21-27 only apply if Mississippi is the home state, as defined in § 83-21-18, see § 83-21-18.

Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 89.

CJS.

44 C.J.S., Insurance § 138.

§ 83-21-21. Surplus lines policies.

(1) The Commissioner of Insurance may establish a stamping procedure for all eligible nonadmitted/surplus lines insurance policies sold on risks subject to the payment of premium taxes to the State of Mississippi.

(2) The Commissioner of Insurance may rely upon the advice and assistance of a duly constituted association of surplus lines insurance producers in carrying out the purposes of this chapter, if the association files with the commissioner:

(a) A copy of the association's constitution and articles of agreement of association or the association's certificate of incorporation and bylaws and any rules and regulations governing the association's activities;

(b) A list of the association's members; and

(c) The name and address of a resident of this state upon whom notices or orders of the commissioner or process issued by the commissioner may be served.

(3) The Commissioner of Insurance may examine the association's records concerning the functions or duties performed on behalf of the commissioner by the association.

(4) The association shall provide a means for the examination of all surplus lines coverages written to determine whether such coverages comply with the law and such rules or regulations as may be issued by the Commissioner of Insurance.

(5) The Commissioner of Insurance may refuse to accept, or may suspend or revoke the acceptance of, an association for any of the following reasons:

(a) It reasonably appears that the association will not be able to carry out the purposes of this chapter;

(b) The association does not maintain and enforce rules and regulations which will ensure that members of the association and persons associated with those members will comply with this chapter, other applicable state law or rules or regulations promulgated under either;

(c) The rules or regulations of the association do not ensure a fair representation of its members in the selection of directors and in the administration of its affairs;

(d) The rules or regulations of the association do not provide for an equitable allocation of reasonable dues, fees and other charges among members;

(e) The rules or regulations of the association impose an undue burden on competition; or

(f) The association fails to meet other applicable requirements prescribed in this chapter.

(6) A surplus lines insurance producer shall cooperate with the association and the Commissioner of Insurance in fulfilling the surplus lines agent's statutory responsibility under this chapter.

(7) Upon request from the association, the Commissioner of Insurance may approve the levy of an examination fee of not more than one percent (1%) of premiums charged under this chapter for the operation of the association to the extent that such operation relieves the commissioner of duties otherwise required of the Commissioner of Insurance under this chapter.

(8) The association may revoke the membership of, and the Commissioner of Insurance may revoke the license in this state of, any licensee who fails to pay the examination fee when due, if the examination fee has been approved by the Commissioner of Insurance.

(9) The fees levied and collected by the association pursuant to this section shall be subject to transfer to the Department of Insurance Special Fund by act of the Legislature.

(10) The association, the association's board members and employees shall not be subject to liability for any functions or duties performed in good faith, from and after May 9, 2008, by the association pursuant to this chapter.

(11) In the alternative, the Commissioner of Insurance may contract with a third party to assist the commissioner with carrying out the purposes of this chapter. The third party may collect an examination fee in an amount determined by the commissioner but not more than one percent (1%) of premiums charged under this chapter. The fees shall be collected and deposited into the Department of Insurance Special Fund, and from this fund the department may pay the third party a reasonable fee for its services.

(12) Notwithstanding the provisions of Section 83-21-18(3), any stamping procedure established under this section may apply to the reporting, payment, collection and allocation of premium taxes for nonadmitted insurance consistent with any agreement, compact or procedures entered into by the commissioner under Section 83-21-18(1).

(13) The commissioner may promulgate rules and regulations necessary for the implementation of this section.

HISTORY: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; 1942, § 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1997, ch. 467, § 1; Laws, 2002, ch. 321, § 1; Laws, 2004, ch. 555, § 15; Laws, 2008, ch. 539, § 1; Laws, 2009, ch. 440, § 1; Laws, 2011, ch. 380, § 4, eff from and after passage (approved Mar. 11, 2011).

Editor's Notes — Laws of 2008, ch. 507, § 8, as amended by Laws of 2009, ch. 440, § 2, provides:

"SECTION 8. The State Fiscal Officer is directed to transfer the sum of Two Million Dollars ($2,000,000.00) from the Mississippi Surplus Lines Association to the Mississippi Department of Insurance Special Funds. Furthermore, should the association between the Mississippi Department of Insurance and the Mississippi Surplus Lines Association cease as to the collection of stamping fees, then any and all unexpended monies, interest and fees in excess of One Million Dollars ($1,000,000.00) collected and held by the Mississippi Surplus Lines Association shall immediately transfer to the State Fiscal Officer for the Mississippi Department of Insurance Special Funds."

Laws of 2015, ch. 471, § 5, provides:

"SECTION 5. The State Fiscal Officer shall transfer the sum of Three Million Dollars ($3,000,000.00) from the Mississippi Surplus Lines Association to the Mississippi Department of Insurance Rural Fire Truck Acquisition Fund and/or the Supplemental Rural Fire Truck Fund. The Mississippi Department of Insurance shall notify the State Fiscal Officer which of those two (2) fund(s) that the Three Million Dollars ($3,000,000.00) shall be transferred to."

Cross References — Provisions of §§ 83-21-19 through 83-21-27 only apply if Mississippi is the home state, as defined in § 83-21-18, see § 83-21-18.

Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

JUDICIAL DECISIONS

ANALYSIS

1. Constitutionality.
2. Taking.

1. Constitutionality.

District court found that the Eleventh Amendment to the U.S. Constitution did not bar an association from proceeding with an action against Mississippi's fiscal officer in his official capacity, alleging that powers he was given under amendments to Miss. Code Ann. § 83-21-21 violated the Fifth and Fourteenth Amendments to the U.S. Constitution because he was able to take private property without just compensation, but that it could not hear claims the association made against the State of Mississippi or a claim it made against the fiscal officer which alleged that the amendments violated Miss. Const. Art. 3, § 17. Miss. Surplus Lines Ass'n v. Mississippi, 384 F. Supp. 2d 982, 2005 U.S. Dist. LEXIS 18454 (S.D. Miss. 2005).

2. Taking.

Nonprofit corporation was accepted by the Insurance Commissioner as the association of surplus lines agents to provide the Commissioner with advice and assistance as provided in Miss. Code Ann. § 83-21-21(3); surplus funds collected by the nonprofit as examination fees under the auspices of the Commissioner were not private funds, so the taking of those funds did not offend the Constitution. Miss. Surplus Lines Ass'n v. Mississippi, 442 F. Supp. 2d 335, 2006 U.S. Dist. LEXIS 57272 (S.D. Miss. 2006), aff'd, 261 Fed. Appx. 781, 2008 U.S. App. LEXIS 855 (5th Cir. Miss. 2008).

OPINIONS OF THE ATTORNEY GENERAL

The Mississippi Surplus Lines Association (MSLA) is a nonprofit corporation which performs a governmental function, i.e., assisting the Commissioner of Insurance in the regulation of foreign insurance companies. As a nonprofit corporation, the MSLA would not be a "public body" as defined in §§ 25-41-3(a) or 25-61-3(a), and would not be subject to the requirements of the Open Meetings Law or the Mississippi Public Records Act of 1983. Dale, July 16, 2004, A.G. Op. 04-0300.

With regard to the State Tort Claims Act and sovereign immunity, the Mississippi Surplus Lines Association would not be within the definition of "political subdivision" therein and would not be subject to its provisions. Dale, July 16, 2004, A.G. Op. 04-0300.

With regard to the public purchasing and contracting provisions contained in §§ 31-7-1 et seq., the Mississippi Surplus Lines Association would not fall within the definition of "agency" or "governing authority" and, therefore, would not be subject to the provisions of that chapter. Dale, July 16, 2004, A.G. Op. 04-0300.

The officers and employees of the Mississippi Surplus Lines Association (MSLA) would not be public officers or public servants by virtue of their office or employment with MSLA and, consequently, the conflicts of interest provisions in Miss. Const., Art. 4, § 109 and § 25-4-101 et seq., prohibiting certain activities and business relationships by public officers and public servants and certain relatives, would not be applicable solely based on their relationships with the MSLA. However, these same individuals may be subject to these prohibitions if they hold public office or are employed by state or local government. Dale, July 16, 2004, A.G. Op. 04-0300.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 89.

CJS.
44 C.J.S., Insurance § 138.

§ 83-21-23. Surplus lines insurance producer required to execute and retain form setting forth certain facts; promulgation of rules and regulations and establishment of fees; exemption of certain surplus lines insurance producers from requirement to make due diligence search to determine availability of full amount or type of insurance from admitted insurers under certain circumstances.

(1) When any policy of personal lines insurance is procured under the authority of such license, the surplus lines insurance producer shall furnish to the insured at the time of policy deliverance an informational notice as promulgated by the commissioner. The informational notice shall address the following:

(a) The insurance procured may or may not be available from the admitted market that may provide greater protection with more regulatory oversight;

(b) In the event of an insolvency of the surplus lines insurer, losses shall not be paid by the Mississippi Insurance Guaranty Association;

(c) The coverage has been procured through a duly licensed nonadmitted insurance producer; and

(d) Any other information the commissioner believes should be disclosed to the insured.

(2) The Commissioner of Insurance may promulgate rules and regulations and establish appropriate fees for the implementation of Sections 83-21-17 through 83-21-31.

HISTORY: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; § 1942, § 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1993, ch. 308, § 1; Laws, 1995, ch. 314, § 1; Laws, 2000, ch. 606, § 2; Laws, 2011, ch. 380, § 5; Laws, 2012, ch. 309, § 1; Laws, 2017, ch. 339, § 2, eff from and after July 1, 2017.

Cross References — Provisions of §§ 83-21-19 through 83-21-27 only apply if Mississippi is the home state, as defined in § 83-21-18, see § 83-21-18.

Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

Federal Aspects — Nonadmiteed and Reinsurance Reform Act of 2010, see 15 USCS § 8201 et seq.

OPINIONS OF THE ATTORNEY GENERAL

Potential insured who wishes to purchase insurance in Mississippi must purchase coverage for those risks, including amount of coverage of risk, which can be covered by admitted company before seeking to cover risks, or higher limits on risks, from approved but nonadmitted companies. Jackson, July 15, 1992, A.G. Op. #92-0450.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 89.

CJS.
44 C.J.S., Insurance § 138.

§ 83-21-25. Report of surplus lines insurance producer; "gross premiums"; designation of procuring surplus lines insurance producer to make report and payment; exemption from payment of surplus line premium tax on certain property risk.

(1) The surplus lines insurance producer shall report under oath to the Commissioner of Insurance, within thirty (30) days from the first of January and July of each year, the amount of gross premiums received by him for such insurance in nonadmitted insurers, and shall pay to the Commissioner of Insurance a tax of four percent (4%) thereon. The term "gross premiums" shall mean the total gross amount of premiums received on each and every surplus lines insurance contract, less returned premiums. In default of the payment of any sum which may be due the state under this law, the Commissioner of Insurance may sue for the same. The surplus lines insurance producer shall keep a separate record of all transactions, as herein provided, open at all times to the inspection of the Commissioner of Insurance. The surplus lines insurance producer may designate another surplus lines insurance producer that actually procured the insurance from the nonadmitted insurer to report and pay, on behalf of the surplus lines insurance producer, to the Commissioner of

Insurance the tax due the state under this law. The surplus lines insurance producer designated to pay the tax shall be deemed to have the same obligations and responsibilities for reporting and paying the tax due the state on the insurance procured from the nonadmitted insurer as the surplus lines insurance producer who was initially responsible for reporting and paying the tax, and the Commissioner of Insurance may sue such surplus lines insurance producer designated to pay the tax in the event such surplus lines insurance producer is in default of any sum which is due the state for which the designated surplus lines insurance producer is responsible or obligated to pay.

(2) [Repealed].

HISTORY: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; 1942, § 5705-02; Laws, 1954, ch. 307, § 2; Laws, 1958, ch. 448, § 1; Laws, 1966, ch. 532, § 1; Laws, 1993, ch. 308, § 2; Laws, 2011, ch. 380, § 6; Laws, 2012, ch. 350, § 1, eff from and after passage (approved Apr. 16, 2012).

Editor's Notes — Subsection (2), which read: "Notwithstanding any provision herein to the contrary, the four percent (4%) tax required in subsection (1) of this section shall not apply to any property risk written by and through the Department of Finance and Administration on behalf of the State of Mississippi. This subsection shall stand repealed from and after July 1, 2013," was repealed by its own terms effective July 1, 2013.

Cross References — Privilege taxes on agents, see §§ 27-15-87 et seq.

Provisions of §§ 83-21-19 through 83-21-27 only apply if Mississippi is the home state, as defined in § 83-21-18, see § 83-21-18.

Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 89.

CJS.
44 C.J.S., Insurance § 138.

§ 83-21-27. Permissible acts of surplus lines insurance producers.

Nothing contained in Sections 83-21-17 through 83-21-31 shall authorize any person, firm, association, or corporation to guarantee or otherwise validate or secure the performance or legality of any agreement, instrument, or policy of insurance of any nonadmitted insurer, nor to permit or authorize any nonadmitted insurer to do any insurance business by or through any person or surplus lines insurance producer acting within this state; but surplus lines insurance producers licensed hereunder acting pursuant to the cited sections may issue and deliver to their clients, the insured, binders, policies, and other confirmation of direct insurance so lawfully placed, and shall not be personally liable to the holder of any policy of insurance so issued or delivered for any loss covered thereby.

HISTORY: Codes, 1906, § 2609; Hemingway's 1917, § 5072; 1930, § 5195; 1942, § 5705-03; Laws, 1954, ch. 307, § 3; Laws, 1958, ch. 448, § 2; Laws, 2011, ch. 380, § 7, eff from and after passage (approved Mar. 11, 2011).

Cross References — Provisions of §§ 83-21-19 through 83-21-27 only apply if Mississippi is the home state, as defined in § 83-21-18, see § 83-21-18.

Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

JUDICIAL DECISIONS

1. In general.

Assumption agreement by which non-admitted insurer assumed liability under policy written by another non-admitted insurer was an effort on the part of the second insurer to validate the original policy and guarantee the performance thereof, and was contrary to the provisions of this statute. Goff v. Dixon, 311 So. 2d 642, 1975 Miss. LEXIS 1615 (Miss. 1975).

Where agent who was not licensed to place insurance with non-admitted companies and agent who was so licensed shared commissions paid for insurance which was not lawfully placed with non-admitted company, agents were joint adventurers and jointly and severally liable under this statute. Goff v. Dixon, 311 So. 2d 642, 1975 Miss. LEXIS 1615 (Miss. 1975).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 89.

CJS.

44 C.J.S., Insurance § 138.

§ 83-21-29. Suits against nonadmitted insurers.

A nonadmitted insurer may be sued upon any cause of action arising in this state under any contract issued by it as hereinabove authorized, in a court of competent jurisdiction in any county in which the plaintiff may reside, or in which the cause of action arose. Any such policy or contract shall contain a provision authorizing service of citation or other legal process upon a person or firm whose name and address shall be set out therein, which said person, or at least one (1) member of a firm, shall be a resident of Mississippi. In lieu thereof any such policy or contract shall contain a provision authorizing service of citation or other legal process upon the Commissioner of Insurance, designating the person to whom said Commissioner of Insurance shall mail citation or other legal process. In the event service of legal process against a nonadmitted insurer is made by service upon the Commissioner of Insurance, he shall forthwith mail citation or other document or process required to the person designated by the nonadmitted insurer in the policy for the purpose by registered mail or certified mail with return receipt requested. In the event of service of citation or other legal process upon the Commissioner of Insurance, the nonadmitted insurer shall have thirty (30) days from date of service upon said Commissioner of Insurance within which to plead, answer, or otherwise defend the action. Upon service of process upon the Insurance Commissioner in accordance with this law, or upon the person or firm designated in the policy or contract in accordance with this law, or as provided for by the Mississippi Rules of Civil Procedure, the court shall be deemed to have jurisdiction in personam of the nonadmitted insurer. A nonadmitted insurer issuing such insurance policy or contract shall be deemed thereby to have authorized service of process upon it in the manner and effect as provided in Sections 83-21-17 through 83-21-31, and as provided in the Mississippi Rules of Civil Procedure.

HISTORY: Codes, 1942, § 5705-04; Laws, 1954, ch. 307, § 4; Laws, 1958, ch. 448, § 3; Laws, 1991, ch. 573, § 121; Laws, 2011, ch. 380, § 8, eff from and after passage (approved Mar. 11, 2011).

Cross References — Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

For the rule governing service of process on foreign companies, see Miss. Rule of Civil Proc. 4.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 94.

CJS.

44 C.J.S., Insurance § 137.

Lawyers' Edition.

State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

§ 83-21-31. Application of preceding and succeeding sections.

As to any policy or contract issued pursuant to Sections 83-21-17 through 83-21-31, and as to any claim for loss or damage arising under any such policy or contract, the cited sections shall apply. As to any such policy or contract issued by an unauthorized insurer in a manner not provided in said preceding sections, Sections 83-21-33 through 83-21-51 shall apply.

HISTORY: Codes, 1942, § 5705-05; Laws, 1954, ch. 307, § 5.

Cross References — Promulgation of rules and regulations and establishment of fees for implementation of this section, see § 83-21-23.

JUDICIAL DECISIONS

1. In general.

In determining the status as an agent of an individual arranging insurance with an unauthorized insurer, § 83-17-1 was the appropriate section for determining agency where the sections listed in § 83-21-31 as particularly applicable to policies issued by unauthorized insurers did not refer to acts sufficient to constitute an agency relationship. Southeastern Fidelity Ins. Co. v. Gann, 340 So. 2d 429, 1976 Miss. LEXIS 1712 (Miss. 1976).

UNAUTHORIZED INSURERS PROCESS LAW

Sec.	
83-21-33.	Citation.
83-21-35.	Service of process upon unauthorized insurers.
83-21-37.	Acts constituting commissioner as agent.
83-21-39.	Method of service.
83-21-41.	Personal service on agent or representative.
83-21-43.	Time allowed before judgment.
83-21-45.	Defense of action by unauthorized insurer.
83-21-47.	Discretionary continuances.

Sec.
83-21-49. Motions to quash or set aside service.
83-21-51. Attorney fees.

§ 83-21-33. Citation.

Sections 83-21-33 through 83-21-51 may be cited as "The Unauthorized Insurers Process Law."

HISTORY: Codes, 1942, § 5705-21; Laws, 1958, ch. 450, § 11.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 94.

CJS.
44 C.J.S., Insurance § 137.

Practice References.
Business Law Monographs (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-21-35. Service of process upon unauthorized insurers.

The purpose of Sections 83-21-33 through 83-21-51 is to subject certain insurers to the jurisdiction of courts of this state in suits by or on behalf of insureds or beneficiaries under insurance contracts. The legislature declares that it is a subject of concern that many residents of this state hold policies of insurance issued or delivered them in this state by insurers not authorized to do business in this state, thus presenting to such residents the often insuperable obstacle of resorting to distant forums for the purpose of asserting legal rights under such policies. In furtherance of such state interests, the legislature herein provides a method of substituted service of process upon such insurers, declares that in so doing it exercises its power to protect its residents and to define, for the purpose of the cited sections, what constitutes doing business in this state, and also exercises powers and privileges available to the state by virtue of Public Law 15, 79th Congress of the United States, Chapter 20, first session, Section 340, as amended, which declares that the business of insurance and every person engaged therein shall be subject to the laws of the several states.

HISTORY: Codes, 1942, § 5705-11; Laws, 1958, ch. 450, § 1.

Cross References — The rule governing service of process on foreign companies, see Miss. Rule of Civil Proc. 4.

Federal Aspects — Public Law 15, 79th Congress, Chapter 20, § 340, 15 USCS § 1011 et seq.

JUDICIAL DECISIONS

1. In general.

Code 1942, §§ 5705-11 and 5705-12 are in pari materia and must be construed with reference to each other, and in so doing it appears that the legislative intent was that § 5705-12 (the long-arm statute) would be effective when policies of insurance were issued or delivered to policyholders within the state, and it was not intended, without more, that the section would be effective to constitute the insurance commissioner as the agent of an insurance corporation merely authorized to do business, but not actually doing business, within the state. Harris v. Ingalls Shipbuilding Corp., 210 So. 2d 307, 1968 Miss. LEXIS 1495 (Miss. 1968).

Where a foreign insurance company issued and delivered in California a policy of group insurance to plaintiff's employer, a corporation authorized to do business in Mississippi, plaintiff's premiums thereon were not paid to the insurer directly by plaintiff but were deducted and paid by the employer, and the insurer had never applied to do business in Mississippi, had no agents or other individuals in any capacity within the state, and did not solicit business by mail there, the fact that the insurer paid part of plaintiff's hospital bill there was an insufficient minimal contract with Mississippi to constitute the insurance commissioner its agent for service of process in plaintiff's Mississippi action on the contract. Harris v. Ingalls Shipbuilding Corp., 210 So. 2d 307, 1968 Miss. LEXIS 1495 (Miss. 1968).

OPINIONS OF THE ATTORNEY GENERAL

An agent for an unlicensed insurer would be subject to the tax specified in Section 83-21-25. Ford, Sept. 16, 2005, A.G. Op. 05-0395.

RESEARCH REFERENCES

ALR.

Foreign insurance company as subject to service of process in action on policy. 44 A.L.R.2d 416.

Am. Jur.

43 Am. Jur. 2d, Insurance § 94.

CJS.

44 C.J.S., Insurance § 137.

§ 83-21-37. Acts constituting commissioner as agent.

Any of the following acts in this state, effected by mail or otherwise, by an unauthorized or alien insurer: (1) the issuance or delivery of contracts of insurance to residents of this state or to corporations authorized to do business therein, (2) the solicitation of applications for such contracts, (3) the collection of premiums, membership fees, assessments, or other considerations for such contracts, or (4) any other transaction of insurance business is equivalent to and shall constitute an appointment by such insurer of the commissioner of insurance and his successor or successors in office to be its true and lawful agent, upon whom may be served all lawful process in any action, suit, or proceeding instituted by or on behalf of an insured or beneficiary arising out of any such contract of insurance, and any such act shall be signification of its agreement that such service of process is of the same legal force and validity as personal service of process in this state upon such insurer.

HISTORY: Codes, 1942, § 5705-12; Laws, 1958, ch. 450, § 2.

Cross References — For the rule covering service of process on foreign companies, see Miss. Rule of Civil Proc. 4.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Applicability.

1. In general.

Code 1942, §§ 5705-11 and 5705-12 are in pari materia and must be construed with reference to each other, and in so doing it appears that the legislative intent was that § 5705-12 (the long-arm statute) would be effective when policies of insurance were issued or delivered to policyholders within the state, and it was not intended, without more, that the section would be effective to constitute the insurance commissioner as the agent of an insurance corporation merely authorized to do business, but not actually doing business, within the state. Harris v. Ingalls Shipbuilding Corp., 210 So. 2d 307, 1968 Miss. LEXIS 1495 (Miss. 1968).

Where a foreign insurance company issued and delivered in California a policy of group insurance to plaintiff's employer, a corporation authorized to do business in Mississippi, plaintiff's premiums thereon were not paid to the insurer directly by plaintiff but were deducted and paid by the employer, and the insurer had never applied to do business in Mississippi, had no agents or other individuals in any capacity within the state, and did not solicit business by mail there, the fact that the insurer paid part of plaintiff's hospital bill there was an insufficient minimal contact with Mississippi to constitute the insurance commissioner its agent for service of process in plaintiff's Mississippi action on the contract. Harris v. Ingalls Shipbuilding Corp., 210 So. 2d 307, 1968 Miss. LEXIS 1495 (Miss. 1968).

2. Applicability.

Miss Code Ann. § 83-21-37 (Rev. 2011) did not apply to an insured's claim against an insurance producer where the producer was a domestic corporation. Cent. Insurers of Gren., Inc. v. Greenwood, 268 So. 3d 493, 2018 Miss. LEXIS 237 (Miss. 2018).

RESEARCH REFERENCES

ALR.

Foreign insurance company as subject to service of process in action on policy. 44 A.L.R.2d 416.

Am. Jur.

43 Am. Jur. 2d, Insurance § 94.

CJS.

44 C.J.S., Insurance § 137.

§ 83-21-39. Method of service.

Such service of process shall be made by delivering to and leaving with the commissioner of insurance, or some person in apparent charge of his office, two (2) copies thereof and the payment to him of such fees as may be prescribed by law. The commissioner of insurance shall forthwith mail by registered mail or certified mail one of the copies of such process to the defendant at its last known principal place of business, and shall keep a record of all process so served upon him. Such service of process is sufficient, provided notice of such service and a copy of the process are sent within ten (10) days thereafter by registered mail or certified mail by plaintiff or plaintiff's attorney to the defendant at its last known principal place of business, and the defendant's receipt, or receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff or plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear, or within such further time as the court may allow.

HISTORY: Codes, 1942, § 5705-13; Laws, 1958, ch. 450, § 3.

Cross References — Requirement that advisory organization assisting insurer submit at time of registration service and acknowledgement of service of process, see § 83-2-17.

For the rule covering service of process on foreign companies, see Miss. Rule of Civil Proc. 4.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 94.

CJS.
44 C.J.S., Insurance § 137.

Lawyers' Edition.
State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

§ 83-21-41. Personal service on agent or representative.

Service of process in any such action, suit or proceeding shall, in addition to the manner provided in Section 83-21-39, be valid if served upon any person within the state who, in this state on behalf of such insurer, is (1) soliciting insurance, or (2) making, issuing or delivering any contract or insurance, or (3) collecting or receiving any premium, membership fee, assessment, or other consideration for insurance; and a copy of such process is sent within ten (10) days thereafter by registered mail or certified mail by the plaintiff or plaintiff's attorney to the defendant at the last known principal place of business of the defendant, and the defendant's receipt, or the receipt issued by the post office with which the letter is registered, showing the name of the sender of the letter and the name and address of the person to whom the letter is addressed, and the affidavit of the plaintiff or plaintiff's attorney showing a compliance herewith are filed with the clerk of the court in which such action is pending on or before the date the defendant is required to appear, or within such further time as the court may allow. Nothing in Sections 83-21-33 through 83-21-51 shall limit or abridge the right to serve any process, notice, or demand upon any insurer in any other manner now or hereafter permitted by law or the Mississippi Rules of Civil Procedure.

HISTORY: Codes, 1942, § 5705-14; Laws, 1958, ch. 450, § 4; Laws, 1991, ch. 573, § 122, eff from and after July 1, 1991.

Cross References — The rule covering service of process on foreign companies, see Miss. Rule of Civil Proc. 4.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 94.

CJS.
44 C.J.S., Insurance § 137.

§ 83-21-43. Time allowed before judgment.

No plaintiff or complainant shall be entitled to a judgment by default, or a judgment with leave to prove damages, or a judgment pro confesso under Sections 83-21-33 through 83-21-51, until the expiration of thirty (30) days from the date of the filing of the affidavit of compliance.

HISTORY: Codes, 1942, § 5705-15; Laws, 1958, ch. 450, § 5.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 94.

CJS.
44 C.J.S., Insurance § 137.

Lawyers' Edition.
State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

§ 83-21-45. Defense of action by unauthorized insurer.

Before any unauthorized insurer shall file or cause to be filed any pleading in any action, suit, or proceeding instituted against it, such unauthorized insurer shall either (1) deposit cash or securities with the clerk of the court in which such action, suit, or proceeding is pending, or file with such clerk a bond with good and sufficient sureties, to be approved by the court, in an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered in such actions; or (2) procure a certificate of authority to transact the business of insurance in this state.

HISTORY: Codes, 1942, § 5705-16; Laws, 1958, ch. 450, § 6.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 94.

CJS.
44 C.J.S., Insurance § 137.

Lawyers' Edition.
State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

§ 83-21-47. Discretionary continuances.

The court, in any action, suit, or proceeding in which service is made in the manner provided in Sections 83-21-33 through 83-21-51, may, in its discretion, order such postponement as may be necessary to afford the defendant reasonable opportunity to comply with the provisions of Section 83-21-45 and to defend such action.

HISTORY: Codes, 1942, § 5705-17; Laws, 1958, ch. 450, § 7.

RESEARCH REFERENCES

Lawyers' Edition.
State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

§ 83-21-49. Motions to quash or set aside service.

Nothing in Sections 83-21-33 through 83-21-51 is to be construed to prevent an unauthorized foreign or alien insurer from filing a motion to quash a writ, or to set aside service thereof made in the manner provided herein, on the ground either (1) that such unauthorized insurer has not done any of the acts enumerated in Section 83-21-37, or (2) that the person on whom service was made pursuant to Section 83-21-41 was not doing any of the acts therein enumerated.

HISTORY: Codes, 1942, § 5705-18; Laws, 1958, ch. 450, § 8.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 94.

CJS.
44 C.J.S., Insurance § 137.

Lawyers' Edition.
State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

§ 83-21-51. Attorney fees.

In any action against an unauthorized foreign or alien insurer upon a contract of insurance issued or delivered in this state to a resident thereof or to a corporation authorized to do business therein, if the insurer has failed for thirty (30) days after demand prior to the commencement of the action to make payment in accordance with the terms of the contract, and it appears to the court that such refusal was vexatious and without reasonable cause, the court may allow to the plaintiff a reasonable attorney fee and include such fee in any judgment that may be rendered in such action. Such fee shall not exceed twenty-five percent (25%) of the amount which the court or jury finds that the plaintiff is entitled to recover against the insurer, but in no event shall such fee be less than Twenty-five Dollars ($25.00). Failure of an insurer to defend any such action shall be deemed prima facie evidence that its failure to make payment was vexatious and without reasonable cause.

HISTORY: Codes, 1942, § 5705-19; Laws, 1958, ch. 450, § 9.

JUDICIAL DECISIONS

1. In general.

In an insurance policy action in which the insured did not establish that his insurer's refusal to make payment was vexatious and without reasonable cause, he was not allowed the reasonable attorney's fee authorized by statute. America Southwest Corp. v. Underwriters at Lloyds, London, 333 F. Supp. 1333, 1971 U.S. Dist. LEXIS 11063 (S.D. Miss. 1971).

An insurance company which refused to make payment on the ground that there was no coverage under the terms of the policy was not liable for attorney's fees under this section [Code 1942, § 5705-19], where the evidence failed to establish that its refusal was made vexatiously and without reasonable cause. America Southwest Corp. v. Underwriters at Lloyds, London, 333 F. Supp. 1333, 1971 U.S. Dist. LEXIS 11063 (S.D. Miss. 1971).

RESEARCH REFERENCES

Am. Jur.

44A Am. Jur. 2d, Insurance § 1521.

CJS.

44 C.J.S., Insurance § 137.

Lawyers' Edition.

State regulation of judicial proceedings as violating commerce clause (Art I, § 8, cl 3) of Federal Constitution-Supreme Court cases. 100 L. Ed. 2d 1049.

CHAPTER 23.

INSOLVENT INSURANCE COMPANIES; INSURANCE GUARANTY ASSOCIATION

Article 1. Insolvent Companies. 83-23-1
Article 3. Insurance Guaranty Association. 83-23-101
Article 5. Mississippi Life and Health Insurance Guaranty Association Act. 83-23-201

ARTICLE 1.

INSOLVENT COMPANIES.

Sec.
83-23-1. Receivers.
83-23-3. Certain receiverships dispensed with.
83-23-5. Commissioner designated as receiver.
83-23-7. Powers of the court in receiverships.
83-23-9. Application of article.

§ 83-23-1. Receivers.

Whenever it shall appear to the commissioner of insurance of this state that any insurance company incorporated in this state, or incorporated out of this state but doing business herein, (1) is insolvent, or (2) is in such condition that its further transaction of business will be hazardous to its policyholders, to its creditors, or to the public, or (3) has been placed in receivership or liquidation or rehabilitation in some other state or jurisdiction, it shall be his duty to file a petition in the chancery court of the proper county, setting up the facts and praying the appointment of a receiver for such company. If any of said grounds shall exist and the commissioner shall neglect to file such petition, then it may be filed by the attorney general. All laws of this state with respect to receivers shall apply in such proceeding, except that no application for the appointment of a receiver of any insurance company shall be entertained by any court unless filed by one of said officials.

HISTORY: Codes, 1942, § 5643; Laws, 1938, ch. 195; Laws, 1958, ch. 434, § 1.

Cross References — Duty of attorney general to represent state officer in suit brought in official capacity, see § 7-5-39.

Jurisdiction of chancery court to appoint receiver, see § 11-5-151.

Suspension or revocation of certificates of authority on ground of unsound condition, see § 83-1-29.

When commissioner may proceed under this article to take possession and conduct business of certain domestic insurers, see § 83-6-37.

Commissioner's power to order insurer to discontinue certain investment practices, see § 83-19-51.

Powers of Mississippi Life and Health Insurance Guaranty Association with respect to insolvent insurers, see § 83-23-215.

Commissioner's duty to notify Mississippi Life and Health Insurance Guaranty Association with respect to insolvency or impairment of member insurers, see § 83-23-221.

Stay of all actions involving insolvent insurance companies to permit Mississippi Life and Health Insurance Guaranty Association to intervene, see § 83-23-233.

JUDICIAL DECISIONS

1. In general.

Duty and responsibility of the commissioner of insurance is prescribed primarily for the protection of the policyholders and the public, and the sections relating thereto were not intended to deal with the relation existing between the insurance corporation and its stockholders, or to require the commissioner to concern himself with the internal affairs and details of operation or management. Sanders v. Neely, 197 Miss. 66, 19 So. 2d 424, 1944 Miss. LEXIS 276 (Miss. 1944).

RESEARCH REFERENCES

ALR.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Primary insurer's insolvency as affecting excess insurer's liability. 85 A.L.R.4th 729.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 148 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 43 (complaint or declaration, in nature of quo warranto, for order appointing receiver for insurance company and enjoining transaction of business).

CJS.

44 C.J.S., Insurance §§ 181 et seq.

Practice References.

Business Law Monographs (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

Liability of Corporate Officers and Directors, William E. Knepper, Dan A. Bailey, Stacy R. Lane, Katharine B. Bowman, Michael R. Goodstein, Darius N. Kandawalla (Matthew Bender).

§ 83-23-3. Certain receiverships dispensed with.

In the event the company in receivership is a foreign company and a receiver has been appointed in the state of domicile of the impaired company, the court shall dispense with the Mississippi receivership unless the court is of the opinion that a Mississippi receivership will best serve the interest of Mississippi policyholders and claimants.

HISTORY: Codes, 1942, § 5643; Laws, 1938, ch. 195; Laws, 1958, ch. 434, § 2.

Cross References — When commissioner may proceed under this article to take possession and conduct business of certain domestic insurers, see § 83-6-37.

JUDICIAL DECISIONS

1. In general.

Duty and responsibility of the commissioner of insurance is prescribed primarily for the protection of the policyholders and the public, and the sections relating thereto were not intended to deal with the relation existing between the insurance corporation and its stockholders, or to require the commissioner to concern himself with the internal affairs and details of operation or management. Sanders v. Neely, 197 Miss. 66, 19 So. 2d 424, 1944 Miss. LEXIS 276 (Miss. 1944).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 151.

CJS.
44 C.J.S., Insurance § 185.

§ 83-23-5. Commissioner designated as receiver.

In event of the appointment of a receiver of any insurance company, the chancery court having jurisdiction shall designate the commissioner of insurance as such receiver. He shall serve as such without compensation other than his regular salary, but the chancery court may authorize the payment of his actual expenses incurred, and may authorize the employment and compensation of such employees, assistants, and attorneys as may be required in the administration of such receivership.

HISTORY: Codes, 1942, § 5644; Laws, 1938, ch. 195.

Cross References — When commissioner may proceed under this article to take possession and conduct business of certain domestic insurers, see § 83-6-37.

§ 83-23-7. Powers of the court in receiverships.

In the administration of any receivership of an insurance company hereunder, the chancery court having jurisdiction may make all necessary orders, including, among others, (1) an order or orders to rehabilitate such company, which may direct the receiver to take possession of the property of such company, conduct the business thereof, and take such steps toward the removal of the causes and conditions which have made a receivership necessary as the court may direct, (2) an order or orders to liquidate such company, (3) an order or orders to terminate such receivership and permit such insurance company to resume possession of its property and the conduct of its business, and (4) an order or orders to conserve the assets of such insurance company within this state.

HISTORY: Codes, 1942, § 5645; Laws, 1938, ch. 195.

Cross References — When commissioner may proceed under this article to take possession and conduct business of certain domestic insurers, see § 83-6-37.

RESEARCH REFERENCES

ALR.
Primary insurer's insolvency as affecting excess insurer's liability. 85 A.L.R.4th 729.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 150 et seq.

CJS.
44 C.J.S., Insurance §§ 195 et seq.

§ 83-23-9. Application of article.

This article shall apply to original receiverships and to ancillary receiverships.

This article shall apply to all insurance companies operating under the insurance laws of this state including stock, mutual, fraternal benefit, and reciprocal or interinsurance companies, and to all corporations operating under Sections 83-41-201 through 83-41-217.

HISTORY: Codes, 1942, § 5646; Laws, 1938, ch. 195; Laws, 1997, ch. 307, § 4, eff from and after July 1, 1997.

ARTICLE 3.

INSURANCE GUARANTY ASSOCIATION.

Sec.

83-23-101. Title.
83-23-103. Purpose.
83-23-105. Application of article; exceptions.
83-23-107. Construction.
83-23-109. Definitions.
83-23-111. Creation of the association.
83-23-113. Board of directors.
83-23-115. Powers and duties of association.
83-23-117. Plan of operation.
83-23-119. Duties and powers of the commissioner.
83-23-121. Assignment of rights to association; effect of paid claims.
83-23-123. Nonduplication of recovery.
83-23-125. Prevention of insolvencies.
83-23-127. Examination of the association.
83-23-129. Tax exemption.
83-23-131. Recognition of assessments in rates.
83-23-133. Immunity.
83-23-135. Stay of proceedings; access to insolvent insurer's records.
83-23-137. Proposal for disbursal of assets of insolvent insurer; application for approval.

§ 83-23-101. Title.

This article shall be known and may be cited as the Mississippi Insurance Guaranty Association Law.

HISTORY: Codes, 1942, § 5814-51; Laws, 1970, ch. 446, § 1, eff from and after passage (approved April 6, 1970).

Cross References — Mississippi Life and Health Insurance Guaranty Association Act, see §§ 83-23-201 et seq.

Applicability of this chapter to nonprofit medical liability insurance corporations, see § 83-47-23.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Illustrative cases.

1. In general.

As a matter of law, the Mississippi Insurance Guaranty Association cannot be liable for punitive damages. Bobby Kitchens, Inc. v. Mississippi Ins. Guaranty Ass'n, 560 So. 2d 129, 1989 Miss. LEXIS 447 (Miss. 1989).

2. Illustrative cases.

In suit by an auto accident victim against the tortfeasor's employer's insurer, which became insolvent, the trial court properly granted the Mississippi Insurance Guaranty Association summary judgment, as the policy at issue excluded coverage for injuries arising from auto accidents, and the fact that the victim pled theories of negligent hiring and failure to maintain adequate safety programs did not defeat the exclusion. Meyers v. Miss. Ins. Guar. Ass'n, 883 So. 2d 10, 2003 Miss. LEXIS 298 (Miss. 2003).

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of statute establishing compensation for claims not paid because of insurer's insolvency. 30 A.L.R.4th 1110.

Primary insurer's insolvency as affecting excess insurer's liability. 85 A.L.R.4th 729.

Practice References.

Business Law Monographs (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-23-103. Purpose.

The purpose of this article is to provide a mechanism for the payment of covered claims under certain insurance policies to avoid excessive delay in payment and to avoid financial loss to claimants or policyholders because of the insolvency of an insurer, to assist in the detection and prevention of insurer insolvencies, and to provide an association to assess the cost of such protection among insurers.

HISTORY: Codes, 1942, § 5814-52; Laws, 1970, ch. 446, § 2, eff from and after passage (approved April 6, 1970).

Cross References — Applicability of this article to nonprofit medical liability insurance corporations, see § 83-47-23.

JUDICIAL DECISIONS

1. In general.

Summary judgment was properly granted in favor of the guaranty association where the insurer's failure to settle within the policy limits when the offer was made, combined with its failure to inform its insured of such offer, automatically operated to extend the insurer's limits to the full amount of the judgment rendered; the insurer did not have standing to bring the suit since its policy limits were extended to cover the entire judgment against the corporation, and no subrogation would be allowed under Miss. Code

Ann. § 83-23-103. Home Ins. Co. v. Miss. Ins. Guar. Ass'n, 904 So. 2d 95, 2004 Miss. LEXIS 13 (Miss. 2004).

The sole purpose of the Mississippi Insurance Guaranty Association (MIGA) is to protect the insured from insolvent insurance companies and to require the financially healthy insurance companies to involuntarily contribute to protect the public. Because of MIGA's involuntary nature, the legislature rightfully placed limitations on the liabilities of Association members. Even so restricted, however, the purpose of protecting the public or claimants against financial loss because of insolvency of insurers must be achieved. To achieve this desirable result, the statute creating MIGA must be liberally construed. Bobby Kitchens, Inc. v. Mississippi Ins. Guaranty Ass'n, 560 So. 2d 129, 1989 Miss. LEXIS 447 (Miss. 1989).

RESEARCH REFERENCES

ALR.

Validity, construction and effect of Uniform Insurer's Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance, §§ 93, 94 et seq., 148.

CJS.

44 C.J.S., Insurance § 182.

§ 83-23-105. Application of article; exceptions.

This article shall apply to all kinds of direct insurance except the following:

(a) Life, annuity, health or disability insurance;

(b) Mortgage guaranty, financial guaranty or other forms of insurance offering protection against insolvent risks;

(c) Fidelity or surety bonds, or any other bonding obligations;

(d) Credit insurance;

(e) Insurance of warranties or service contracts;

(f) Title insurance;

(g) Ocean marine insurance;

(h) Any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) which involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk; and

(i) Any insurance provided by or guaranteed by government.

HISTORY: Codes, 1942, § 5814-53; Laws, 1970, ch. 446, § 3; Laws, 1992, ch. 412, § 1, eff from and after July 1, 1992.

Cross References — Definition of "member insurer," see § 83-23-109.

Insurance guaranty association for life and health insurance, see §§ 83-23-201 et seq.

JUDICIAL DECISIONS

1. In general.

Chancellor did not err in finding in favor of the insurance companies in their action, in part, for reimbursement of claims because claims at issue were covered claims under direct insurance; therefore, the Mississippi Insurance Guaranty Association was responsible for paying those claims under Miss. Code Ann. § 83-23-105, and was required to reimburse the insurance companies. Miss. Ins. Guar. Ass'n v. MS Cas. Ins. Co., 947 So. 2d 865, 2006 Miss. LEXIS 622 (Miss. 2006).

Major medical insurance or accident and health insurance is exempt from Mississippi Insurance Guaranty Association insolvency coverage. Mississippi Ins. Guaranty Asso. v. Vaughn, 529 So. 2d 540, 1988 Miss. LEXIS 224 (Miss. 1988).

Liability of insurance guaranty association is not limited to claims arising after the effective date of the act creating the association, but extends to any claim antedating insolvency. Mississippi Ins. Guaranty Asso. v. Gandy, 289 So. 2d 677, 1973 Miss. LEXIS 1210 (Miss. 1973).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 148 et seq.

CJS.
44 C.J.S., Insurance §§ 181 et seq.

§ 83-23-107. Construction.

This article shall be liberally construed to effect the purpose under Section 83-23-103, which shall constitute an aid and guide to interpretation.

HISTORY: Codes, 1942, § 5814-54; Laws, 1970, ch. 446, § 4, eff from and after passage (approved April 6, 1970).

JUDICIAL DECISIONS

1. In general.

The Mississippi Insurance Guaranty Association Law (§ 83-23-101 et seq) is to be liberally construed in order to achieve the purpose of protecting the public or claimants against financial loss because of the insolvency of insurers. Mississippi Ins. Guaranty Ass'n v. Byars, 614 So. 2d 959, 1993 Miss. LEXIS 76 (Miss. 1993).

The sole purpose of the Mississippi Insurance Guaranty Association (MIGA) is to protect the insured from insolvent insurance companies and to require the financially healthy insurance companies to involuntarily contribute to protect the public. Because of MIGA's involuntary nature, the legislature rightfully placed limitations on the liabilities of Association members. Even so restricted, however, the purpose of protecting the public or claimants against financial loss because of insolvency of insurers must be achieved. To achieve this desirable result, the statute creating MIGA must be liberally construed. Bobby Kitchens, Inc. v. Mississippi Ins. Guaranty Ass'n, 560 So. 2d 129, 1989 Miss. LEXIS 447 (Miss. 1989).

§ 83-23-109. Definitions.

As used in this article:

(a) "Affiliate" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year next preceding the date the insurer becomes an insolvent insurer.

(b) "Association" means the Mississippi Insurance Guaranty Association created under Section 83-23-111.

(c) "Claimant" means any insured making a first-party claim or any person instituting a liability claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

(d) "Commissioner" means the Commissioner of Insurance.

(e) "Control" means the possession, direct or indirect, of the power to direct or cause direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten percent (10%) or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

(f) "Covered claim" means an unpaid claim, including one of unearned premiums, which arises out of and is within the coverage and not in excess of the applicable limits of an insurance policy to which this article applies issued by an insurer, if such insurer becomes an insolvent insurer and (i) the claimant or insured is a resident of this state at the time of the insured event, provided that for entities other than an individual, the residence of a claimant or insured is the state in which its principal place of business is located at the time of the insured event; or (ii) the property from which the claim arises is permanently located in this state. "Covered claim" shall not include any amount awarded as punitive or exemplary damages; or sought as a return of premium under any retrospective rating plan; or due any reinsurer, insurer, insurance pool, or underwriting association, as subrogation recoveries or otherwise and shall preclude recovery thereof from the insured of any insolvent carrier to the extent of the policy limits. "Covered claim" shall not include any claim that would otherwise be a covered claim under this article that has been rejected or denied by any other state guaranty fund based upon that state's statutory exclusions regarding the insured's net worth.

(g) "Insolvent insurer" means an insurer licensed to transact insurance in this state either at the time the policy was issued or when the insured event occurred and against whom an order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction, in the insurer's state of domicile or of this state and the order of liquidation has not been stayed or been the subject of a writ of supersedeas or other comparable order.

(h) "Member insurer" means any person who (i) writes any kind of insurance to which this article applies under Section 83-23-105, including the exchange of reciprocal or interinsurance contracts, and (ii) is licensed to transact insurance in this state.

(i) "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this article applies, less return premiums thereon and dividends paid or credited to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

(j) "Person" means any individual, corporation, partnership, association or voluntary organization.

HISTORY: Codes, 1942, § 5814-55; Laws, 1970, ch. 446, § 5; Laws, 1992, ch. 412, § 2, eff from and after July 1, 1992; Laws, 2019, ch. 304, § 1, eff from and after July 1, 2019.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Covered claims.

1. In general.

Trial court correctly granted Mississippi Insurance Guaranty Association's motion for summary judgment on the corporation's action for declaratory relief and damages where, pursuant to Miss. Code Ann. § 83-23-109(f), the underlying tort claimants were not claimants, the corporation was the one asserting the claim; however, residency was not met by the corporation and the claim was not a covered claim. Owens Corning v. Miss. Ins. Guar. Ass'n, 947 So. 2d 944, 2007 Miss. LEXIS 27 (Miss. 2007).

Guaranty association was not liable for insurance policy issued to a property company by an insolvent insurer, as the insurer was not a member of the association, and no assessments were ever collected by the guaranty association. Miss. Ins. Guar. Ass'n v. Goldin Props., 893 So. 2d 1062, 2004 Miss. App. LEXIS 688 (Miss. Ct. App. 2004), cert. denied, 893 So. 2d 1061, 2005 Miss. LEXIS 121 (Miss. 2005).

An insurance claim arose from a well, which was permanently located in Mississippi, rather than the well's tubing, which was easily transported, and was therefore covered under § 83-23-109, even though some of the damages claimed necessarily involved the tubing indirectly, where all of the claimed damages were in some way concerned either with the well itself or with steps taken to return the well to useful service. Mississippi Ins. Guar. Ass'n v. Harkins & Co., 652 So. 2d 732, 1995 Miss. LEXIS 145 (Miss. 1995).

An unpaid insurance claim qualified as a "covered claim" under § 83-23-109(c), even though the insurance policy was purchased as a surplus lines policy in Louisiana, where the insurance company was licensed in Mississippi at the applicable time. Mississippi Ins. Guar. Ass'n v. Harkins & Co., 652 So. 2d 732, 1995 Miss. LEXIS 145 (Miss. 1995).

An insurance claim was a "covered claim" under the Mississippi Insurance Guaranty Association Law (§§ 83-23-101 et seq.), even though the insured was a Michigan corporation and not a Mississippi resident, where the claimant was a resident of Mississippi, since § 83-23-109(c) requires that the insured or the claimant be a resident of Mississippi in order to fall under the Mississippi Insurance Guaranty Association's umbrella. Mississippi Ins. Guaranty Ass'n v. Byars, 614 So. 2d 959, 1993 Miss. LEXIS 76 (Miss. 1993).

2. Covered claims.

Insured's claim against his uninsured motorist carrier was a covered claim under Miss. Code Ann. § 83-23-109(f) because at the time of the insured's accident with a truck, the truck was insured by an insurance company that had since been declared an insolvent insurer within the meaning of § 83-23-109; therefore, the insured's claim was unquestionably a "covered claim," a claim against the Mississippi Insurance Guaranty Association. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 396, 2010 Miss. LEXIS 60 (Miss. 2010).

Summary judgment was properly granted to the Mississippi Insurance Guaranty Association because it was entitled to offset an amount recovered by an injured party from its own insurer under Miss. Code Ann. § 83-23-123 since a covered claim was filed under Miss. Code Ann. § 83-23-109(f) under an uninsured motorist provision. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 405, 2009 Miss. App. LEXIS 104 (Miss. Ct. App. 2009), aff'd, 27 So. 3d 396, 2010 Miss. LEXIS 60 (Miss. 2010).

Under Miss. Code Ann. § 83-23-109(f), a covered claim is an unpaid claim, with a few restrictions, that is issued by an insurer, if such insurer becomes an insolvent insurer and meets condition (1) or (2) of the definition. Miss. Ins. Guar. Ass'n v. Cole, 954 So. 2d 407, 2007 Miss. LEXIS 123 (Miss. 2007).

Clear and unambiguous key to the definition of covered claim is that a covered claim, under the Mississippi Insurance Guaranty Association Law, relates to circumstances involving a once-solvent insurer that becomes insolvent. Miss. Ins. Guar. Ass'n v. Cole, 954 So. 2d 407, 2007 Miss. LEXIS 123 (Miss. 2007).

Mother and child were not required to first exhaust their rights under an insurance policy as set forth in Miss. Code Ann. § 83-23-123(1) where their physicians' insurance carrier had remained solvent at all times, and as a result the claim against them related to the birth of the child was not a covered claim. Miss. Ins. Guar. Ass'n v. Cole, 954 So. 2d 407, 2007 Miss. LEXIS 123 (Miss. 2007).

Chancellor did not err in finding in favor of the insurance companies in their action, in part, for reimbursement of claims because claims at issue were "covered claims" under direct insurance; therefore, the Mississippi Insurance Guaranty Association was responsible for paying those claims under Miss. Code Ann. § 83-23-109(f), and was required to reimburse the insurance companies. Miss. Ins. Guar. Ass'n v. MS Cas. Ins. Co., 947 So. 2d 865, 2006 Miss. LEXIS 622 (Miss. 2006).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 148 et seq.

CJS.
44 C.J.S., Insurance §§ 181 et seq.

§ 83-23-111. Creation of the association.

There is created a nonprofit unincorporated legal entity to be known as the Mississippi Insurance Guaranty Association. All insurers defined as member insurers in Section 83-23-109 shall be and remain members of the association as a condition of their authority to transact insurance in this state. The association shall perform its functions under a plan of operation established and approved under Section 83-23-117 and shall exercise its powers through a board of directors established under Section 83-23-113.

HISTORY: Codes, 1942, § 5814-56; Laws, 1970, ch. 446, § 6, eff from and after passage (approved April 6, 1970).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 63.

§ 83-23-113. Board of directors.

(1) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) persons, serving terms as established in the plan of operation. The members of the board shall be selected by member insurers, subject to the approval of the commissioner. Vacancies of the board shall be filled for the remaining period of the term by a majority vote of the remaining board members subject to the approval of the commissioner. If no members are selected within sixty (60) days after July 1, 1992, the commissioner may appoint the initial members of the board of directors.

(2) In approving selections to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors.

HISTORY: Codes, 1942, § 5814-57; Laws, 1970, ch. 446, § 7; Laws, 1992, ch. 412, § 3, eff from and after July 1, 1992.

Cross References — Plan of operation, see § 83-23-117.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-23-115. Powers and duties of association.

(1) The association shall:

(a) Be obligated to the extent of the covered claims existing prior to the determination of insolvency and arising within thirty (30) days after the determination of insolvency, or before the policy expiration date if less than thirty (30) days after the determination, or before the insured replaces the policy or causes its cancellation if he does so within thirty (30) days of the determination. Such obligation shall be satisfied by paying the claimant an amount as follows:

(i) The full amount of a covered claim for benefits under a workers' compensation insurance coverage;

(ii) An amount in excess of Fifty Dollars ($50.00) per policy for a covered claim for the return of unearned premium;

(iii) An amount in excess of Fifty Dollars ($50.00) but not exceeding Three Hundred Thousand Dollars ($300,000.00) per claimant for all other covered claims.

In no event shall the association be obligated to a policyholder or claimant in an amount in excess of the obligation of the insolvent insurer under the policy from which the claim arises. Notwithstanding any other provisions of this article, a covered claim shall not include a claim filed with the association after final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

(b) Be deemed the insurer to the extent of its obligation on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent.

(c) Assess insurers amounts necessary to pay the obligations of the association under paragraph (a) subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency, and the cost of examinations under Section 83-23-125 and other expenses authorized by this article. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year bears to the net direct written premiums of all member insurers for the preceding calendar year. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any year an amount greater than one percent (1%) of that member insurer's net direct written premiums for the preceding calendar year. If the maximum assessment, together with the other assets of the association, does not provide in any one (1) year an amount sufficient to make all necessary payments, the funds available shall be prorated and the unpaid portion shall be paid as soon thereafter as funds become available. The association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance. Each member insurer may set off, against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer.

(d) Investigate claims brought against the association; adjust, compromise, settle, and pay covered claims to the extent of the association's obligation; deny all other claims; and may review settlements, releases, and judgments to which the insolvent insurer or its insureds were parties, to determine the extent to which such settlements, releases, and judgments may be properly contested.

(e) Notify such persons as the commissioner directs under Section 83-23-119(2)(a).

(f) Handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the commissioner, but such designation may be declined by a member insurer.

(g) Reimburse each servicing facility for obligations of the association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the association, and shall pay the other expenses of the association authorized by this article.

(2) The association may:

(a) Employ or retain such persons as are necessary to handle claims and perform other duties of the association.

(b) Borrow funds necessary to effect the purposes of this article in accord with the plan of operation.

(c) Sue or be sued.

(d) Negotiate and become a party to such contracts as are necessary to carry out the purpose of this article.

(e) Perform such other acts as are necessary or proper to effectuate the purpose of this article.

(f) Refund to the member insurers in proportion to the contribution of each member insurer to the association that amount by which the assets of the association exceed the liabilities if, at the end of any calendar year, the board of directors finds that the assets of the association exceed the liabilities of the association as estimated by the board of directors for the coming year.

HISTORY: Codes, 1942, § 5814-58; Laws, 1970, ch. 446, § 8; Laws, 1992, ch. 412, § 4, eff from and after July 1, 1992; Laws, 2019, ch. 304, § 2, eff from and after July 1, 2019.

Cross References — Board's powers under (1)(c) and (2) (b) of this section cannot be delegated, see § 83-23-117(4).

Suspension or revocation of certificate of authority to transact insurance for failure to comply with plan of operation, see § 83-23-119.

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Construction with other laws.

1. In general.

Because Miss. Code Ann. § 83-23-123(1) specifically provided that any amount payable by the Mississippi Insurance Guaranty Association (MIGA) on a covered claim would be reduced by the amount of any recovery from an insurance policy other than a policy of an insolvent insurer, MIGA was required to reduce the amount payable to an insured by the amount of his uninsured motorist (UM) carrier's UM payment; assuming the insured's damages amount to be $ 300,000 or more, the amount payable on a covered claim by MIGA would be $ 300,000 because the maximum amount payable by MIGA was $ 300,000 under Miss. Code Ann. § 83-23-115((1)(a)(iii), and that full amount had been discharged by the carrier's payment to the insured. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 396, 2010 Miss. LEXIS 60 (Miss. 2010).

The Mississippi Insurance Guaranty Association Law (§ 83-23-101 et seq.) requires that the Mississippi Insurance Guaranty Association (MIGA) assume the insurer's duties and obligations, including the duty to defend the insured; thus, MIGA was liable to a claimant for $300,000 of the policy coverage in question-the maximum amount allowed under the Mississippi Insurance Guaranty Law-where MIGA consciously breached its duty by refusing to attend a settlement conference and refusing in any way to defend the claim since MIGA "stepped into the shoes" of the claimant's insolvent insurer and had a duty to either defend the action or pay the policy proceeds to the claimant. Mississippi Ins. Guaranty Ass'n v. Byars, 614 So. 2d 959, 1993 Miss. LEXIS 76 (Miss. 1993).

While the Mississippi Insurance Guaranty Association (MIGA) is protected by the statutory limitation of $300,000, it is also required by statute to assume the insurer's duties and obligations, which includes the duty to defend the insured. Thus, until MIGA had paid into the court the $300,000, it had a statutory and contractual responsibility to pay or defend. Bobby Kitchens, Inc. v. Mississippi Ins. Guaranty Ass'n, 560 So. 2d 129, 1989 Miss. LEXIS 447 (Miss. 1989).

This section did not make the state guaranty association the statutory successor of an insolvent insurance company, so as to entitle it to judgment in an interpleader action to determine who was entitled to the proceeds of an agreement of reinsurance; the purpose of this section is to allow the association to assert any defenses on a policy that the insolvent insurer would have been entitled to assert. General Reinsurance Corp. v. Missouri General Ins. Co., 458 F. Supp. 1, 1977 U.S. Dist. LEXIS 12379 (W.D. Mo. 1977), aff'd, 596 F.2d 330, 1979 U.S. App. LEXIS 15406 (8th Cir. Mo. 1979).

The Mississippi Insurance Guaranty Association is not in the position to raise the constitutionality of the very statute upon which it depends for its existence. Mississippi Ins. Guaranty Asso. v. Gandy, 289 So. 2d 677, 1973 Miss. LEXIS 1210 (Miss. 1973).

2. Construction with other laws.

Pursuant to Miss. Code Ann. § 82-23-123, a secondary insurer's policy, which contained an other-insurance clause stating that it was in excess to any other primary insurance, was required to be exhausted before the Mississippi Insurance Guaranty Association had a statutory duty under Miss. Code Ann. § 83-23-115(1)(b) to provide coverage under an insolvent carrier's primary policy. Nat'l Union Fire Ins. Co. v. Miss. Ins. Guar. Ass'n, 990 So. 2d 174, 2008 Miss. LEXIS 424 (Miss. 2008).

RESEARCH REFERENCES

ALR.

What constitutes "suit" triggering insurer's duty to defend environmental claims–state cases. 48 A.L.R.5th 355.

Duty of liability insurer to initiate settlement negotiations. 51 A.L.R.5th 701.

Am. Jur.

43 Am. Jur. 2d, Insurance § 67.

§ 83-23-117. Plan of operation.

(1)(a) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the commissioner.

(b) If at any time the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this article. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall:

(a) Establish the procedures whereby all the powers and duties of the association under Section 83-23-115 will be performed.

(b) Establish procedures for handling assets of the association.

(c) Establish the amount and method of reimbursing members of the board of directors under Section 83-23-113.

(d) Establish procedures by which claims may be filed with the association, and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the association or its agent, and a list of such claims shall be periodically submitted to the association or similar organization in another state by the receiver or liquidator.

(e) Establish regular places and times for meetings of the board of directors.

(f) Establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors.

(g) Provide that any member insurer aggrieved by any final action or decision of the association may appeal to the commissioner within thirty (30) days after the action or decision.

(h) Establish the procedures whereby selections for the board of directors will be submitted to the commissioner.

(i) Contain additional provisions necessary or proper for the execution of the powers and duties of the association.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under Section 83-23-115(1)(c) and 83-23-115(2)(b), are delegated to a corporation, association, or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed, and shall be paid for its performance of any other functions of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association, or organization which extends protection not substantially less favorable and effective than that provided by this article.

HISTORY: Codes, 1942, § 5814-59; Laws, 1970, ch. 446, § 9, eff from and after passage (approved April 6, 1970).

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance §§ 148 et seq.	44 C.J.S., Insurance §§ 181 et seq.

§ 83-23-119. Duties and powers of the commissioner.

(1) The commissioner shall:

(a) Notify the association of the existence of an insolvent insurer not later than three (3) days after he receives notice of the determination of the insolvency.

(b) Upon request of the board of directors, provide the association with a statement of the net direct written premiums of each member insurer.

(2) The commissioner may:

(a) Require that the association notify the insureds of the insolvent insurer and any other interested parties of the determination of insolvency and of their rights under this article. Such notification shall be by mail at their last-known address, where available, but if sufficient information for notification by mail is not available, notice by publication in a newspaper of general circulation shall be sufficient.

(b) Suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment when due, or fails to comply with the plan of operation. As an alternative, the commissioner may levy a fine on any member insurer which fails to pay an assessment when due. Such fine shall not exceed five percent (5%) of the unpaid assessment per month, except that no fine shall be less than One Hundred Dollars ($100.00) per month.

(c) Revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily.

(3) Any final action or order of the commissioner under this article shall be subject to judicial review in a court of competent jurisdiction.

HISTORY: Codes, 1942, § 5814-60; Laws, 1970, ch. 446, § 10, eff from and after passage (approved April 6, 1970).

Cross References — Commissioner's power to order insurer to discontinue certain investment practices, see § 83-19-51.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 67, 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

§ 83-23-121. Assignment of rights to association; effect of paid claims.

(1) Any person recovering under this article shall be deemed to have assigned his rights under the policy to the association to the extent of his recovery from the association. Every insured or claimant seeking the protection of this article shall cooperate with the association to the same extent as such person would have been required to cooperate with the insolvent insurer. The association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer, and except as provided in subsection (2). In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the association shall not operate to reduce the liability of insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

(2) The association shall have the right to recover from the following persons the amount of any "covered claim" paid on behalf of such person pursuant to this article:

Any person who is an affiliate of the insolvent insurer and whose liability obligations to other persons are satisfied in whole or in part by payments made under this article.

(3) The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by settlements of covered claims by the association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this article against the assets of the insolvent insurer. The expenses of the association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

(4) The association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the association and estimates of anticipated claims on the association, which shall preserve the rights of the association against the assets of the insolvent insurer.

HISTORY: Codes, 1942, § 5814-61; Laws, 1970, ch. 446, § 11; Laws, 1992, ch. 412, § 5, eff from and after July 1, 1992.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 157 et seq.

CJS.
44 C.J.S., Insurance § 196.

§ 83-23-123. Nonduplication of recovery.

(1) Any person having a claim against an insurer under any provision in an insurance policy other than a policy of an insolvent insurer, which is also a covered claim, shall be required to exhaust first his right under such policy. Any amount payable on a covered claim under this article shall be reduced by the amount of any recovery under such insurance policy.

(2) Any person having a claim which may be recovered under more than one (1) insurance guaranty association or its equivalent shall seek recovery first from the association of the place of residence of the insured, except that if it is a first party claim for damage to property with a permanent location, he shall seek recovery first from the association of the location of the property, and if it is a workmen's compensation claim, he shall seek recovery first from the association of the residence of the claimant. Any recovery under this article shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

HISTORY: Codes, 1942, § 5814-62; Laws, 1970, ch. 446, § 12, eff from and after passage (approved April 6, 1970).

JUDICIAL DECISIONS

ANALYSIS

1. Liability.
2. Exhaustion requirement.
3. Claim against an insurer.

1. Liability.

Because Miss. Code Ann. § 83-23-123(1) specifically provided that any amount payable by the Mississippi Insurance Guaranty Association (MIGA) on a covered claim would be reduced by the amount of any recovery from an insurance policy other than a policy of an insolvent insurer, MIGA was required to reduce the amount payable to an insured by the amount of his uninsured motorist (UM) carrier's UM payment; assuming the insured's damages amount to be $ 300,000 or more, the amount payable on a covered claim by MIGA would be $ 300,000 because the maximum amount payable by MIGA was $ 300,000 under Miss. Code Ann. § 83-23-115((1)(a)(iii), and that full amount had been discharged by the carrier's payment to the insured. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 396, 2010 Miss. LEXIS 60 (Miss. 2010).

Under Miss. Code Ann. § 83-23-123(2), the Mississippi Insurance Guaranty Association was liable for claims to the reinsurer from nonresident claimants whose policyholders were located in Mississippi at the time of the insured event if those claimants first tried to seek recovery in their home states and were denied; it was clear that the chancellor did not err in his finding because he unquestionably adhered to the statutory scheme of recovery. Miss. Ins. Guar. Ass'n v. MS Cas. Ins. Co., 947 So. 2d 865, 2006 Miss. LEXIS 622 (Miss. 2006).

2. Exhaustion requirement.

Under the exhaustion of other insurance provision of Miss. Code Ann. § 83-23-123(1) (1999), the Mississippi Insurance Guaranty Association had to offset or reduce its obligation to pay a covered claim from an insolvent workers' compensation insurer where the injured employee recovered on the same claim in a settlement with an uninsured motorist carrier, which was the full obligation of that insurer. Miss. Ins. Guar. Ass'n v. Blakeney, 54 So. 3d 203, 2011 Miss. LEXIS 28 (Miss. 2011).

Where an injured plaintiff has alternative sources of insurance covering the same claim as the claim against an insolvent insurer, a nonduplication provision in Miss. Code Ann. § 83-23-123 requires the plaintiff to exhaust the solvent policy and deduct the amount recovered from the obligation due by a state insurance guaranty association. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 405, 2009 Miss. App. LEXIS 104 (Miss. Ct. App. 2009), aff'd, 27 So. 3d 396, 2010 Miss. LEXIS 60 (Miss. 2010).

Summary judgment was properly granted to the Mississippi Insurance Guaranty Association because it was entitled to offset an amount recovered by an injured party from its own insurer under Miss. Code Ann. § 83-23-123 since a covered claim was filed under Miss. Code Ann. § 83-23-109(f) under an uninsured motorist provision. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 405, 2009 Miss. App. LEXIS 104 (Miss. Ct. App. 2009), aff'd, 27 So. 3d 396, 2010 Miss. LEXIS 60 (Miss. 2010).

Because Mississippi Insurance Guaranty Association (MIGA) stepped into the shoes of an insolvent carrier and was bound by the rights, duties, and obligations of the insolvent insurer, it was not entitled to a credit for amounts that the insured received from her employer's uninsured motorist coverage; such recovery was explicitly forbidden under the Mississippi Supreme Court's prior Cossitt decision, and MIGA's contentions that it should be bound only by the exhaustion provision of the Mississippi Insurance Guaranty Association Law were without merit; nothing in the language of Miss. Code Ann. § 83-23-123(1) indicated that the exhaustion provision superseded any other law regarding a carrier's right to recovery. Miss. Ins. Guar. v. Blakeney, 51 So. 3d 208, 2009 Miss. App. LEXIS 870 (Miss. Ct. App. 2009), rev'd, 54 So. 3d 203, 2011 Miss. LEXIS 28 (Miss. 2011).

Pursuant to Miss. Code Ann. § 82-23-123, a secondary insurer's policy, which contained an other-insurance clause stating that it was in excess to any other primary insurance, was required to be exhausted before the Mississippi Insurance Guaranty Association had a statutory duty under Miss. Code Ann. § 83-23-115(1)(b) to provide coverage under an insolvent carrier's primary policy. Nat'l Union Fire Ins. Co. v. Miss. Ins. Guar. Ass'n, 990 So. 2d 174, 2008 Miss. LEXIS 424 (Miss. 2008).

Clear and unambiguous reading of the exhaustion provision, Miss. Code Ann. § 83-23-123(1), states that a person who has a covered claim against an insurer under any insurance policy provision must exhaust his other rights under the policy. Miss. Ins. Guar. Ass'n v. Cole, 954 So. 2d 407, 2007 Miss. LEXIS 123 (Miss. 2007).

3. Claim against an insurer.

Insured had a claim against an insurer pursuant to Miss. Code Ann. § 83-23-123(1) because he was covered by an insurance policy that included uninsured motorist coverage; there was no assertion that the uninsured motorist carrier was an insolvent insurer. Leitch v. Miss. Ins. Guar. Ass'n, 27 So. 3d 396, 2010 Miss. LEXIS 60 (Miss. 2010).

RESEARCH REFERENCES

ALR.

Primary insurer's insolvency as affecting excess insurer's liability. 85 A.L.R.4th 729.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 157 et seq.

CJS.

44 C.J.S., Insurance § 196.

§ 83-23-125. Prevention of insolvencies.

To aid in the detection and prevention of insurer insolvencies:

(a) It shall be the duty of the board of directors, upon majority vote, to notify the commissioner of any information indicating any member insurer may be insolvent or in a financial condition hazardous to the policyholders or the public.

(b) The board of directors may, upon majority vote, request that the commissioner order an examination of any member insurer which the board in good faith believes may be in a financial condition hazardous to the policyholders or the public. Within thirty (30) days of the receipt of such request, the commissioner shall begin such examination. The examination may be conducted as a National Association of Insurance Commissioners examination, or may be conducted by such persons as the commissioner designates. The cost of such examination shall be paid by the association, and the examination report shall be treated as are other examination reports. In no event shall such examination report be released to the board of directors prior to its release to the public, but this shall not preclude the commissioner from complying with subsection (c). The commissioner shall notify the board of directors when the examination is completed. The request for an examination shall be kept on file by the commissioner, but it shall not be open to public inspection prior to the release of the examination report to the public.

(c) It shall be the duty of the commissioner to report to the board of directors when he has reasonable cause to believe that any member insurer examined or being examined at the request of the board of directors may be insolvent or in a financial condition hazardous to the policyholders or the public.

(d) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation, or conservation of any member insurer. Such reports and recommendations shall not be considered public documents.

(e) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of insurer insolvencies.

(f) The board of directors shall, at the conclusion of any insurer insolvency in which the association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the association, and submit such report to the commissioner.

HISTORY: Codes, 1942, § 5814-63; Laws, 1970, ch. 446, § 13, eff from and after passage (approved April 6, 1970).

Cross References — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 148 et seq.
14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 42 (petition or application for order liquidating and dissolving insolvent insurance company and enjoining transaction of business); Form No. 44 (order to show cause why insolvent insurance company should not be liquidated and dissolved and enjoined from transacting business); Form No. 45 (order liquidating and dissolving insolvent insurance company and enjoining transaction of business by and actions against insurance company).

CJS.
44 C.J.S., Insurance §§ 181 et seq.

§ 83-23-127. Examination of the association.

The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

HISTORY: Codes, 1942, § 5814-64; Laws, 1970, ch. 446, § 14, eff from and after passage (approved April 6, 1970).

Cross References — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance § 96.

§ 83-23-129. Tax exemption.

The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.

HISTORY: Codes, 1942, § 5814-65; Laws, 1970, ch. 446, § 15, eff from and after passage (approved April 6, 1970).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 63.

CJS.
44 C.J.S., Insurance §§ 118-120.

§ 83-23-131. Recognition of assessments in rates.

The rates and premiums charged for insurance policies to which this article applies may include amounts sufficient to recoup a sum equal to the amounts paid to the association by the member insurer less any amounts returned to the member insurer by the association. Such rates shall not be deemed excessive because they contain an amount reasonably calculated to recoup assessments paid by the member insurer.

HISTORY: Codes, 1942, § 5814-66; Laws, 1970, ch. 446, § 16, eff from and after passage (approved April 6, 1970).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 73.

CJS.
44 C.J.S., Insurance §§ 81-83.

§ 83-23-133. Immunity.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer, the association, its agents or employees, the board of directors, or the commissioner or his representatives for any action taken or any failure to act by them in the performance of their powers and duties under this article.

HISTORY: Codes, 1942, § 5814-67; Laws, 1970, ch. 446, § 17; Laws, 1992, ch. 412, § 6, eff from and after July 1, 1992.

JUDICIAL DECISIONS

1. In general.
A potential suit against individual agents of the Mississippi Insurance Guaranty Association is acknowledged by statute and not prohibited, if the action in question involves negligence or bad faith. Bobby Kitchens, Inc. v. Mississippi Ins. Guaranty Ass'n, 560 So. 2d 129, 1989 Miss. LEXIS 447 (Miss. 1989).

RESEARCH REFERENCES

ALR.
What constitutes "suit" triggering insurer's duty to defend environmental claims–state cases. 48 A.L.R.5th 355.

§ 83-23-135. Stay of proceedings; access to insolvent insurer's records.

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall be stayed for six (6) months and for such additional time thereafter as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the state, whichever is later, to permit proper defense by the association of all pending causes of action as to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the insolvent insurer or its failure to defend an insured. The association, either on its own behalf or on behalf of such insured, may apply to have such judgment, order, decision, verdict, or finding set aside by the same court or administrator that made such judgment, order, decision, verdict, or finding, and shall be permitted to defend against such claim on the merits.

The liquidator, receiver, or statutory successor of an insolvent insurer covered by this article shall permit access by the board or its authorized representative to the insolvent insurer's records which are necessary for the board in carrying out its functions under this article with regard to covered claims. In addition, the liquidator, receiver, or statutory successor shall provide the board or its representative with copies of such records upon the request by the board and at the expense of the board.

HISTORY: Codes, 1942, § 5814-68; Laws, 1970, ch. 446, § 18; Laws, 1992, ch. 412, § 7, eff from and after July 1, 1992.

JUDICIAL DECISIONS

1. In general.

Where the employee was injured when a forklift struck him in the head at work and landed on top of him, he filed suit against the forklift manufacturer and the retailer for negligence, breach of warranty, and design defect. The trial court granted a motion to stay proceedings filed by the retailer pursuant to Miss. Code Ann. § 83-23-135, because its liability insurer was experiencing financial difficulties and was placed into liquidation; the proceedings were stayed for six months from the date of insolvency. Townsend v. Doosan Infracore Am. Corp., 3 So. 3d 150, 2009 Miss. App. LEXIS 92 (Miss. Ct. App. 2009).

Trial court did not err by denying defendants' claim for a stay on the grounds that its malpractice insurer had been placed in liquidation as the insurer's policy holders were not covered under the Mississippi Insurance Guaranty Association. Byrd v. Bowie, 933 So. 2d 899, 2006 Miss. LEXIS 179 (Miss. 2006).

Statute did not provide basis for relief from default judgment where final judgment was entered before defendant's insurance company was adjudicated insolvent, and Circuit Court wholly respected its duty under statute and once 60 day automatic stay expired, court properly took action and denied motion seeking relief from default judgment. H & W Transfer & Cartage Service, Inc. v. Griffin, 511 So. 2d 895, 1987 Miss. LEXIS 2610 (Miss. 1987).

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of statute establishing compensation for claims not paid because of insurer's insolvency. 30 A.L.R.4th 1110.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 148 et seq.

CJS.

44 C.J.S., Insurance §§ 181 et seq.

§ 83-23-137. Proposal for disbursal of assets of insolvent insurer; application for approval.

(1) Within one hundred twenty (120) days of a final determination of insolvency of an insurer by a court of competent jurisdiction, the receiver, liquidator or statutory successor shall make application to the court for approval of a proposal to disburse assets out of such insurer's marshalled assets, from time to time as such assets become available to each association entitled thereto. For the purposes of this section, the term "association"

includes the Mississippi Insurance Guaranty Association and any entity or person performing a function in another state similar to that performed in this state by the Mississippi Insurance Guaranty Association, provided the Mississippi Insurance Guaranty Association is entitled to like payment under the laws of the other's state of domicile with respect to insolvent companies doing business in that state.

(2) Such proposal shall at least include provisions for:

(a) Reserving amounts for the payment of expenses of administration, the payment of claims of secured creditors to the extent of the value of the security held, and the payment of claims falling within the priorities established in this article.

(b) Disbursement of the other assets marshalled to date and subsequent disbursements of assets as they become available.

(c) Equitable allocation of disbursements to each association entitled thereto.

(d) The securing by the receiver, liquidator or statutory successor, from each association entitled to disbursements pursuant to this section, of an agreement to return to it such assets previously disbursed as may be required to pay claims of secured creditors and claims falling within the priorities established in this article, in accordance with such priorities; however, no bond shall be required of any such association.

(e) A full report to be made by each association to the receiver, liquidator or statutory successor, which report shall account for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets, and any other matter as the court may direct.

(3) The proposal of the receiver, liquidator or statutory successor shall provide for disbursements to each association in amounts at least equal to the claim payments made, and estimated to be made, by such association for which such association could assert a claim against the receiver, and shall provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made, or to be made, by each such association, then disbursements shall be in the amount of available assets.

(4) Notice of such application shall be given by the receiver, liquidator or statutory successor to the associations in, and to the commissioners of insurance of, each of the states to which disbursement may be made. Such notice shall be made by certified mail, first class postage prepaid, at least thirty (30) days prior to submission of such application to the court. Such notice shall be deemed to have been made when deposited in the mail.

(5) Action on the application may be taken by the court if notice has been given pursuant to subsection (4) of this section and the proposal of the receiver, liquidator or statutory successor complies with subsection (2) of this section.

HISTORY: Laws, 1981, ch. 346, § 1, eff from and after passage (approved March 18, 1981).

RESEARCH REFERENCES

ALR.

Validity, construction and effect of Uniform Insurer's Liquidation Act. 46 A.L.R.2d 1185.

ARTICLE 5.

MISSISSIPPI LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT.

Sec.	
83-23-201.	Citation of article.
83-23-203.	Purpose.
83-23-205.	Applicability of article.
83-23-207.	Construction of article.
83-23-209.	Definitions.
83-23-211.	Mississippi Life and Health Insurance Guaranty Association; member insurers; functions; accounts.
83-23-213.	Board of directors; selection; compensation.
83-23-215.	Powers of association.
83-23-217.	Assessments against member insurers; classes; refunds; treatment of assessments on financial statements of member insurers; protest of assessment.
83-23-218.	Member insurers permitted to offset assessment against taxes.
83-23-219.	Plan of operation; approval by commissioner; contents of plan.
83-23-221.	Duties of commissioner; enforcement of assessments against member insurers; appeal.
83-23-223.	Detection and prevention of member insurer insolvencies or impairments.
83-23-225.	Liability of insolvent or impaired insurer for assessments.
83-23-227.	Regulation by commissioner; annual report.
83-23-229.	Tax status of association.
83-23-231.	Immunity of member insurers, employees, directors of association and similar organizations.
83-23-233.	Stay of judicial proceedings upon order of liquidation, rehabilitation, or conservation.
83-23-235.	Use of association's name in insurance advertisements or solicitations; association to prepare document describing general purposes and limitations of association.
83-23-237.	Applicability of amendments by Chapter 358, Laws of 2014.
83-23-239.	Amendments by Chapter 304, Laws of 2020, to this article not applicable to member insurers placed under liquidation order.

§ 83-23-201. Citation of article.

This article shall be known and may be cited as the "Mississippi Life and Health Insurance Guaranty Association Act".

HISTORY: Laws, 1985, ch. 482, § 1, eff from and after passage (approved April 9, 1985).

Cross References — Mississippi Insurance Guaranty Association Law, see §§ 83-23-101 et seq.

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.

44 C.J.S., Insurance § 197.

Law Reviews.

Alexander L. Ash, Comment: It's Your Money and We Want It Now: Regulation of the Structured Settlement Factoring Industry in the Era of Dodd-Frank and the Consumer Financial Protection Bureau, 86 Miss. L.J. 151 (2017).

Practice References.

Business Insurance Law and Practice Guide (Matthew Bender Elite Products).

Business Law Monographs (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-23-203. Purpose.

(1) The purpose of this article is to protect, subject to certain limitations, the persons specified in Section 83-23-205(1) against failure in the performance of contractual obligations, under life, health, and annuity policies, plans or contracts specified in Section 83-23-205(2), because of the impairment or insolvency of the member insurer that issued the policies, plans or contracts.

(2) To provide this protection, an association of member insurers is created to pay benefits and to continue coverages as limited herein, and members of the association are subject to assessment to provide funds to carry out the purpose of this article.

HISTORY: Laws, 1985, ch. 482, § 2; Laws, 1990, ch. 546, § 1, eff from and after July 1, 1990; Laws, 2020, ch. 304, § 1, eff from and after July 1, 2020.

Cross References — Liberal construction of article to effectuate legislative purpose, see § 83-23-207.

JUDICIAL DECISIONS

1. In general.

Insured couple's misrepresentation claims against the life insurance company that purchased the assets of an insolvent insurer from whom the couple had purchased their policies failed because the company assumed no liability caused by any alleged fraudulent misrepresentations or omissions of the insurer or its agents; the company had not assumed any obligations other than the covered obligations and the policy unequivocally stated premiums were due for life. Gregory v. Cent. Sec. Life Ins. Co., 953 So. 2d 233, 2007 Miss. LEXIS 205 (Miss. 2007).

Purpose of the Mississippi Life and Health Guaranty Association is not to give claimants more than they would have received had the insurer with which they dealt been held directly accountable for the amounts owed rather than sheltered by the tent of bankruptcy proceedings. Bank of Miss. v. Miss. Life & Health Ins. Guar. Ass'n, 850 So. 2d 127, 2003 Miss. App. LEXIS 137 (Miss. Ct. App. 2003).

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.

44 C.J.S., Insurance § 197.

§ 83-23-205. Applicability of article.

(1) This article shall provide coverage for the policies and contracts specified in subsection (2)(a) of this section:

(a) To persons who, regardless of where they reside (except for nonresident certificate holders under group policies or contracts), are the beneficiaries, assignees or payees, including health care providers rendering services covered under health insurance policies or certificates, of the persons covered under paragraph (b);

(b) To persons who are owners of or certificate holders or enrollees under the policies or contracts (other than unallocated annuity contracts and structured settlement annuities) and in each case who:

(i) Are residents; or

(ii) Are not residents, but only under all of the following conditions:

1. The member insurer that issued the policies or contracts is domiciled in this state;

2. The states in which the persons reside have associations similar to the association created by this article;

3. The persons are not eligible for coverage by an association in any other state due to the fact that the insurer or health maintenance organization was not licensed in the state at the time specified in the state's guaranty association law.

(c) For unallocated annuity contracts specified in subsection (2)(a) of this section, paragraphs (a) and (b) of this subsection shall not apply, and this article shall (except as provided in paragraphs (e) and (f) of this subsection) provide coverage to:

(i) Persons who are the owners of the unallocated annuity contracts if the contracts are issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; and

(ii) Persons who are owners of unallocated annuity contracts issued to or in connection with government lotteries if the owners are residents.

(d) For structured settlement annuities specified in subsection (2)(a) of this section, paragraphs (a) and (b) of this subsection shall not apply, and this article shall (except as provided in paragraphs (e) and (f) of this subsection) provide coverage to a person who is a payee under a structured settlement annuity (or beneficiary of a payee if the payee is deceased), if the payee:

(i) Is a resident, regardless of where the contract owner resides, or

(ii) Is not a resident, but only under both of the following conditions:

1.a. The contract owner of the structured settlement annuity is a resident, or

b. The contract owner of the structured settlement annuity is not a resident, but (A) the insurer that issued the structured settlement annuity is domiciled in this state; and (B) the state in which the contract owner resides has an association similar to the association created by this article; and

2. Neither the payee (or beneficiary) nor the contract owner is eligible for coverage by the association of the state in which the payee or contract owner resides.

(e) This article shall not provide coverage to:

(i) A person who is a payee (or beneficiary) or a contract owner resident of this state, if the payee (or beneficiary) is afforded any coverage by the association of another state;

(ii) A person covered under paragraph (c) of this subsection, if any coverage is provided by the association of another state to the person; or

(iii) A person who acquires rights to receive payments through a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after 26 U.S.C. 5891(c)(3)(A) became effective.

(f) This article is intended to provide coverage to a person who is a resident of this state and in special circumstances, to a nonresident. In order to avoid duplicate coverage, if a person who would otherwise receive coverage under this article is provided coverage under the laws of any other state, the person shall not be provided coverage under this article. In determining the application of the provisions of this paragraph, in situations where a person could be covered by the association of more than one (1) state, whether as an owner, payee, enrollee, beneficiary or assignee, this article shall be construed in conjunction with other state laws to result in coverage by only one (1) association.

(2)(a) This article shall provide coverage to the persons specified in subsection (1) of this section for policies or contracts of direct, nongroup life insurance, health insurance (which for the purposes of this article includes health maintenance organization subscriber contracts and certificates), or annuities and supplemental contracts to any of these, for certificates under direct group policies and contracts, and for unallocated annuity contracts issued by member insurers, except as limited by this article. Annuity contracts and certificates under group annuity contracts include, but are not limited to, guaranteed investment contracts, deposit administration contracts, unallocated funding agreements, allocated funding agreements, structured settlement annuities, annuities issued to or in connection with government lotteries and any immediate or deferred annuity contracts.

(b) Except as otherwise provided in subsection (3) of this section, this article shall not provide coverage for:

(i) A portion of a policy or contract not guaranteed by the member insurer, or under which the risk is borne by the policy or contract owner;

(ii) A policy or contract of reinsurance, unless assumption certificates have been issued pursuant to the reinsurance policy or contract;

(iii) A portion of a policy or contract to the extent that the rate of interest on which it is based, or the interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value:

1. Averaged over the period of four (4) years prior to the date on which the member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier, exceeds the rate of interest determined by subtracting two (2) percentage points from Moody's Corporate Bond Yield Average averaged for that same four-year period or for such lesser period if the policy or contract was issued less than four (4) years before the member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier; and

2. On and after the date on which the member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier, exceeds the rate of interest determined by subtracting three (3) percentage points from Moody's Corporate Bond Yield Average as most recently available;

(iv) A portion of a policy or contract issued to a plan or program of an employer, association or other person to provide life, health or annuity benefits to its employees, members or others to the extent that the plan or program is self-funded or uninsured, including, but not limited to, benefits payable by an employer, association or other person under:

1. A Multiple Employer Welfare Arrangement as defined in 29 U.S.C. Section 1002(40);

2. A minimum premium group insurance plan;

3. A stop-loss group insurance plan; or

4. An administrative services only contract;

(v) A portion of a policy or contract to the extent that it provides for:

1. Dividends or experience-rating credits;

2. Voting rights; or

3. Payment of any fees or allowances to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(vi) A policy or contract issued in this state by a member insurer at a time when it was not licensed or did not have a certificate of authority to issue such policy or contract in this state;

(vii) An unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payments with respect to the benefit plan;

(viii) A portion of any unallocated annuity contract that is not issued to or in connection with a specific employee, union or association of natural persons benefit plan or a government lottery;

(ix) A portion of a policy or contract to the extent that the assessments required by Section 83-23-217 with respect to the policy or contract are preempted by federal or state law;

(x) An obligation that does not arise under the express written terms of the policy or contract issued by the member insurer to the enrollee, certificate holder, contract owner or policy owner, including without limitation:

1. Claims based on marketing materials;
2. Claims based on side letters, riders or other documents that were issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;
3. Misrepresentations of or regarding policy or contract benefits;
4. Extra-contractual claims; or
5. A claim for penalties or consequential or incidental damages;

(xi) A contractual agreement that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by the benefit plan or its trustee, which in each case is not an affiliate of the member insurer;

(xii) A portion of a policy or contract to the extent it provides for interest or other changes in value to be determined by the use of an index or other external reference stated in the policy or contract, but which have not been credited to the policy or contract, or as to which the policy or contract owner's rights are subject to forfeiture, as of the date the member insurer becomes an impaired or insolvent insurer under this article, whichever is earlier. If a policy's or contract's interest or changes in value are credited less frequently than annually, then for purposes of determining the values that have been credited and are not subject to forfeiture under this paragraph, the interest or change in value determined by using the procedures defined in the policy or contract will be credited as if the contractual date of crediting interest or changing values was the date of impairment or insolvency, whichever is earlier, and will not be subject to forfeiture; and

(xiii) A policy or contract providing any hospital, medical, prescription drug or other health care benefits pursuant to Part C or Part D of Subchapter XVIII, Chapter 7 of Title 42 of the United States Code (commonly known as Medicare Part C & D), or Subchapter XIX, Chapter 7 of Title 42 of the United States Code (commonly known as Medicaid), or any regulations issued pursuant thereto.

(xiv) Structured settlement annuity benefits to which a payee (or beneficiary) has transferred his or her rights in a structured settlement factoring transaction as defined in 26 U.S.C. 5891(c)(3)(A), regardless of whether the transaction occurred before or after 26 U.S.C. 5891(c)(3)(A) became effective.

(3) The exclusion from coverage referenced in subsection (2)(b)(iii) of this section shall not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other health insurance benefits.

(4) The benefits that the association may become obligated to cover shall in no event exceed the lesser of:

(a) The contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer; or

(b)(i) With respect to any one (1) life, regardless of the number of policies or contracts:

1. Three Hundred Thousand Dollars ($300,000.00) in life insurance death benefits, but not more than One Hundred Thousand Dollars ($100,000.00) in net cash surrender and net cash withdrawal values for life insurance;

2. For health insurance benefits:

a. One Hundred Thousand Dollars ($100,000.00) for coverages not defined as disability income insurance or health benefit plans or long-term care insurance, including any net cash surrender and net cash withdrawal values;

b. Three Hundred Thousand Dollars ($300,000.00) for disability income insurance and Three Hundred Thousand Dollars ($300,000.00) for long-term care insurance;

c. Five Hundred Thousand Dollars ($500,000.00) for health benefit plans;

3. Two Hundred Fifty Thousand Dollars ($250,000.00) in the present value of annuity benefits, including net cash surrender and net cash withdrawal values; or

(ii) With respect to each individual participating in a governmental retirement benefit plan established under Section 401, 403(b) or 457 of the United States Internal Revenue Code covered by an unallocated annuity contract or the beneficiaries of each such individual if deceased, in the aggregate, Two Hundred Fifty Thousand Dollars ($250,000.00) in present value annuity benefits, including net cash surrender and net cash withdrawal values;

(iii) With respect to each payee of a structured settlement annuity (or beneficiary or beneficiaries of the payee if deceased), Two Hundred Fifty Thousand Dollars ($250,000.00) in present value annuity benefits, in the aggregate, including net cash surrender and net cash withdrawal values, if any;

(iv) However, in no event shall the association be obligated to cover more than (a) an aggregate of Three Hundred Thousand Dollars ($300,000.00) in benefits with respect to any one (1) life under paragraphs (b)(i), (b)(ii) and (b)(iii) of this subsection except with respect to benefits for health benefit plans under paragraph (b)(i) of this subsection, in which case the aggregate liability of the association shall not exceed Five Hundred Thousand Dollars ($500,000.00) with respect to any one (1) individual, or (b) with respect to one (1) owner of multiple nongroup policies of life insurance, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, more than

Five Million Dollars ($5,000,000.00) in benefits, regardless of the number of policies and contracts held by the owner;

(v) With respect to either (a) one (1) contract owner provided coverage under subsection (1)(c)(ii) of this section; or (b) one (1) plan sponsor whose plans own directly or in trust one or more unallocated annuity contracts not included in paragraph (b)(ii) of this subsection, Five Million Dollars ($5,000,000.00) in benefits, irrespective of the number of contracts with respect to the contract owner or plan sponsor. However, in the case where one or more unallocated annuity contracts are covered contracts under this article and are owned by a trust or other entity for the benefit of two (2) or more plan sponsors, coverage shall be afforded by the association if the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in this state and in no event shall the association be obligated to cover more than Five Million Dollars ($5,000,000.00) in benefits with respect to all these unallocated contracts;

(vi) The limitations set forth in this subsection are limitations on the benefits for which the association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies. The costs of the association's obligations under this article may be met by the use of assets attributable to covered policies or reimbursed to the association pursuant to its subrogation and assignment rights;

(vii) For purposes of this article, benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

(5) In performing its obligations to provide coverage under Section 83-23-215, the association shall not be required to guarantee, assume, reinsure, reissue or perform, or cause to be guaranteed, assumed, reinsured, reissued or performed, the contractual obligations of the insolvent or impaired insurer under a covered policy or contract that do not materially affect the economic values or economic benefits of the covered policy or contract.

HISTORY: Laws, 1985, ch. 482, § 3; Laws, 1990, ch. 546, § 2; Laws, 1999, ch. 365, § 1; Laws, 2014, ch. 358, § 1, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 2, eff from and after July 1, 2020.

Cross References — Insurance guaranty association for other kinds of insurance, see §§ 83-23-101 et seq.

Purpose of this article, see § 83-23-203.

Definition of "covered policy" and "member insurer," see § 83-23-209.

For definitions applicable to this article, see § 83-23-209.

Powers of Mississippi Life and Health Insurance Guaranty Association, see § 83-23-215.

Federal Aspects — Sections 401, 403(b), 457 of the Internal Revenue Code, see 26 USCS §§ 401, 403(b) and 457. Definition of multiple employer welfare arrangement, 29 USCS § 1002. Federal Pension Benefit Guaranty Corporation, 29 USCS §§ 1301 et seq.

JUDICIAL DECISIONS

ANALYSIS

1. Interest rates.
2. Liability for misrepresentation.

1. Interest rates.

Where the liquidator of an insolvent insurer provided a replacement annuity to the trust set up for the beneficiaries of the original annuity, and the trust sued the Mississippi Life and Health Guaranty Association to recover the beneficiaries' losses, the circuit court correctly applied the interest rates provided in the substitute annuity in calculating damages owed by the Association, because to use any others would have given the trust a windfall to the detriment of the general public. Bank of Miss. v. Miss. Life & Health Ins. Guar. Ass'n, 850 So. 2d 127, 2003 Miss. App. LEXIS 137 (Miss. Ct. App. 2003).

2. Liability for misrepresentation.

Insured couple's misrepresentation claims against the life insurance company that purchased the assets of an insolvent insurer from whom the couple had purchased their policies failed because the company assumed no liability caused by any alleged fraudulent misrepresentations or omissions of the insurer or its agents; the company had not assumed any obligations other than the covered obligations and the policy unequivocally stated premiums were due for life. Gregory v. Cent. Sec. Life Ins. Co., 953 So. 2d 233, 2007 Miss. LEXIS 205 (Miss. 2007).

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.

44 C.J.S., Insurance § 197.

§ 83-23-207. Construction of article.

This article shall be construed to effect the purpose under Section 85-23-203.

HISTORY: Laws, 1985, ch. 482, § 4; Laws, 1999, ch. 365, § 2, eff from and after passage (approved Mar. 15, 1999).

Cross References — Statement of legislative intent, see § 83-23-203.

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.

44 C.J.S., Insurance § 197.

§ 83-23-209. Definitions.

As used in this article:

(a) "Account" means either of the two (2) accounts created under Section 83-23-211.

(b) "Association" means the Mississippi Life and Health Insurance Guaranty Association created under Section 83-23-211.

(c) "Authorized assessment" or the term "authorized" when used in the context of assessments means a resolution by the board of directors has been passed whereby an assessment will be called immediately or in the future from member insurers for a specified amount. An assessment is authorized when the resolution is passed.

(d) "Benefit plan" means a specific employee, union or association of natural persons benefit plan.

(e) "Called assessment" or the term "called" when used in the context of assessments means that a notice has been issued by the association to member insurers requiring that an authorized assessment be paid within the time frame set forth within the notice. An authorized assessment becomes a called assessment when notice is mailed by the association to member insurers.

(f) "Commissioner" means the Commissioner of Insurance of this state.

(g) "Contractual obligation" means an obligation under a policy or contract or certificate under a group policy or contract, or portion thereof for which coverage is provided under Section 83-23-205.

(h) "Covered contract" or "covered policy" means a policy or contract or portion of a policy or contract for which coverage is provided under Section 83-23-205.

(i) "Extra-contractual claims" shall include, for example, claims relating to bad faith in the payment of claims, punitive or exemplary damages or attorneys' fees and costs.

(j) "Health benefit plan" means any hospital or medical expense policy or certificate, or health maintenance organization subscriber contract or any other similar health contract. "Health benefit plan" does not include:

(i) Accident only insurance;

(ii) Credit insurance;

(iii) Dental only insurance;

(iv) Vision only insurance;

(v) Medicare Supplement insurance;

(vi) Benefits for long-term care, home health care, community-based care, or any combination thereof;

(vii) Disability income insurance;

(viii) Coverage for on-site medical clinics; or

(ix) Specified disease, hospital confinement indemnity or limited benefit health insurance if the types of coverage do not provide coordination of benefits and are provided under separate policies or certificates.

(k) "Impaired insurer" means a member insurer which, after April 9, 1985, is not an insolvent insurer, and is placed under an order of rehabilitation or conservation by a court of competent jurisdiction.

(*l*) "Insolvent insurer" means a member insurer which after April 9, 1985, is placed under an order of liquidation by a court of competent jurisdiction with a finding of insolvency.

(m) "Member insurer" means an insurer or health maintenance organization licensed or that holds a certificate of authority to transact in this state any kind of insurance or a health maintenance organization business for which coverage is provided under Section 83-23-205, and includes any insurer or health maintenance organization whose license or certificate of authority in this state may have been suspended, revoked, not renewed or voluntarily withdrawn, but does not include:

(i) A hospital or medical service organization whether profit or nonprofit;

(ii) A fraternal benefit society;

(iii) A mandatory state pooling plan;

(iv) A mutual assessment company or other person that operates on an assessment basis;

(v) An insurance exchange;

(vi) An organization that has a certificate or license limited to the issuance of charitable gift annuities; or

(vii) An entity similar to any of the above.

(n) "Moody's Corporate Bond Yield Average" means the Monthly Average Corporates as published by Moody's Investors Service, Inc., or any successor thereto.

(o) "Owner" of a policy or contract and "policyholder," "policy owner" and "contract owner" mean the person who is identified as the legal owner under the terms of the policy or contract or who is otherwise vested with legal title to the policy or contract through a valid assignment completed in accordance with the terms of the policy or contract and properly recorded as the owner on the books of the member insurer. The terms owner, contract owner, policyholder and policy owner do not include persons with a mere beneficial interest in a policy or contract.

(p) "Person" means any individual, corporation, limited liability company, partnership, association, governmental body or entity or voluntary organization.

(q) "Plan sponsor" means:

(i) The employer in the case of a benefit plan established or maintained by a single employer;

(ii) The employee organization in the case of a benefit plan established or maintained by an employee organization; or

(iii) In a case of a benefit plan established or maintained by two (2) or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the benefit plan.

(r) "Premiums" means amounts or considerations (by whatever name called) received on covered policies or contracts less returned premiums, considerations and deposits, and less dividends and experience credits. "Premiums" does not include amounts or considerations received for policies or contracts or for the portions of policies or contracts for which coverage is not provided under Section 83-23-205(2), except that assessable premium shall not be reduced on account of Sections 83-23-205(2)(b)(iii) relating to interest limitations and 83-23-205(3)(b) relating to limitations with respect to one (1) individual, one (1) participant and one (1) policy or contract owner. "Premiums" shall not include:

(i) Premiums in excess of Five Million Dollars ($5,000,000.00) on an unallocated annuity contract not issued under a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code; or

(ii) With respect to multiple nongroup policies of life insurance owned by one (1) owner, whether the policy or contract owner is an individual, firm, corporation or other person, and whether the persons insured are officers, managers, employees or other persons, premiums in excess of Five Million Dollars ($5,000,000.00) with respect to these policies or contracts, regardless of the number of policies or contracts held by the owner.

(s) "Principal place of business" of a plan sponsor or a person other than a natural person means the single state in which the natural persons who establish policy for the direction, control and coordination of the operations of the entity as a whole primarily exercise that function, determined by the association in its reasonable judgment by considering the following factors:

(i) The state in which the primary executive and administrative headquarters of the entity is located;

(ii) The state in which the principal office of the chief executive officer of the entity is located;

(iii) The state in which the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(iv) The state in which the executive or management committee of the board of directors (or similar governing person or persons) of the entity conducts the majority of its meetings;

(v) The state from which the management of the overall operations of the entity is directed; and

(vi) In the case of a benefit plan sponsored by affiliated companies comprising a consolidated corporation, the state in which the holding company or controlling affiliate has its principal place of business as determined using the above factors.

However, in the case of a plan sponsor, if more than fifty percent (50%) of the participants in the benefit plan are employed in a single state, that state shall be deemed to be the principal place of business of the plan sponsor.

The principal place of business of a plan sponsor of a benefit plan described in paragraph (q)(iii) of this section shall be deemed to be the principal place of business of the association, committee, joint board of trustees or other similar group of representatives of the parties who establish or maintain the benefit plan that, in lieu of a specific or clear designation of a principal place of business, shall be deemed to be the principal place of business of the employer or employee organization that has the largest investment in the benefit plan in question.

(t) "Receivership court" means the court in the insolvent or impaired insurer's state having jurisdiction over the conservation, rehabilitation or liquidation of the member insurer.

(u) "Resident" means a person to whom a contractual obligation is owed and who resides in this state on the date of entry of a court order that determines a member insurer to be an impaired insurer or a court order that determines a member insurer to be an insolvent insurer, whichever occurs first. A person may be a resident of only one (1) state, which in the case of a person other than a natural person shall be its principal place of business. Citizens of the United States that are either (i) residents of foreign countries, or (ii) residents of United States possessions, territories or protectorates that do not have an association similar to the association created by this article, shall be deemed residents of the state of domicile of the member insurer that issued the policies or contracts.

(v) "Structured settlement annuity" means an annuity purchased in order to fund periodic payments for a plaintiff or other claimant in payment for or with respect to personal injury suffered by the plaintiff or other claimant.

(w) "State" means a state, the District of Columbia, Puerto Rico, and a United States possession, territory or protectorate.

(x) "Supplemental contract" means a written agreement entered into for the distribution of proceeds under a life, health or annuity policy or contract.

(y) "Unallocated annuity contract" means an annuity contract or group annuity certificate which is not issued to and owned by an individual, except to the extent of any annuity benefits guaranteed to an individual by an insurer under such contract or certificate.

HISTORY: Laws, 1985, ch. 482, § 5; Laws, 1990, ch. 546, § 3; Laws, 1999, ch. 365, § 3; Laws, 2014, ch. 358, § 2, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 3, eff from and after July 1, 2020.

Cross References — Scope of article, see § 83-23-205.

Association and its accounts, see § 83-23-211.

Computation of assessments against member insurers, see § 83-23-217.

Federal Aspects — Sections 401, 403(b), 457 of the Internal Revenue Code, see 26 USCS §§ 401, 403(b) and 457.

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.
44 C.J.S., Insurance § 197.

§ 83-23-211. Mississippi Life and Health Insurance Guaranty Association; member insurers; functions; accounts.

(1) There is created a nonprofit legal entity to be known as the Mississippi Life and Health Insurance Guaranty Association. All member insurers shall be and remain members of the association as a condition of their authority to transact insurance or a health maintenance organization business in this state. The association shall perform its functions under the plan of operation established and approved under Section 83-23-219 and shall exercise its powers through a board of directors established under Section 83-23-213. For purposes of administration and assessment the association shall maintain two (2) accounts:

(a) The life insurance and annuity account which includes the following subaccounts:

(i) Life insurance account;

(ii) Annuity account which shall include annuity contracts owned by a governmental retirement plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code, but shall otherwise exclude unallocated annuities; and

(iii) Unallocated annuity account which shall exclude contracts owned by a governmental retirement benefit plan (or its trustee) established under Section 401, 403(b) or 457 of the United States Internal Revenue Code.

(b) The health account.

(2) The association shall come under the immediate supervision of the commissioner and shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records of the association may be opened to the public upon majority vote of the board of directors of the association.

HISTORY: Laws, 1985, ch. 482, § 6; Laws, 1990, ch. 546, § 4; Laws, 1999, ch. 365, § 4, eff from and after passage (approved Mar. 15, 1999); Laws, 2020, ch. 304, § 4, eff from and after July 1, 2020.

Cross References — Definition of "account" and "association," see § 83-23-209.
Board of directors of association, see § 83-23-213.
Association's plan of operation, see § 83-23-219.
Tax status of association, see § 83-23-229.
Federal Aspects — Sections 401, 403(b), 457 of the Internal Revenue Code, see 26 USCS §§ 401, 403(b) and 457.

JUDICIAL DECISIONS

1. In general.

Mississippi Life and Health Insurance Guaranty Association is liable to insured covered by insolvent health insurer only for contractual obligation of insurer, not for attorney fees and punitive damages included in default judgment against insolvent insurer. Rowley v. First Columbia Life Ins. Co., 741 F. Supp. 1259, 1989 U.S. Dist. LEXIS 16991 (S.D. Miss. 1989).

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.

44 C.J.S., Insurance § 197.

§ 83-23-213. Board of directors; selection; compensation.

(1) The board of directors of the association shall consist of not less than five (5) nor more than nine (9) member insurers serving terms as established in the plan of operation. The members of the board shall be selected by member insurers subject to the approval of the commissioner. Vacancies on the board shall be filled for the remaining period of the term by a majority vote of the remaining board members, subject to the approval of the commissioner. To select the initial board of directors, and initially organize the association, the commissioner shall give notice to all member insurers of the time and place of the organizational meeting. In determining voting rights at the organizational meeting each member insurer shall be entitled to one (1) vote in person or by proxy. If the board of directors is not selected within sixty (60) days after notice of the organizational meeting, the commissioner may appoint the initial members.

(2) In approving selections or in appointing members to the board, the commissioner shall consider, among other things, whether all member insurers are fairly represented.

(3) Members of the board may be reimbursed from the assets of the association for expenses incurred by them as members of the board of directors but members of the board shall not otherwise be compensated by the association for their services.

HISTORY: Laws, 1985, ch. 482, § 7, eff from and after passage (approved April 9, 1985).

Cross References — Performance of association's functions through board of directors, see § 83-23-211.

Requirement that plan of operation contain method for reimbursing directors, see § 83-23-219.

Duties of commissioner, see § 83-23-221.

Relationship between board of directors and commissioner in detecting and preventing insolvency or impairment among member insurers, see § 83-23-223.

Immunity of association, commissioner, and their agents and employees, see § 83-23-231.

RESEARCH REFERENCES

ALR.
Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.
What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.
44 C.J.S., Insurance § 197.

§ 83-23-215. Powers of association.

(1) If a member insurer is an impaired insurer, the association may, in its discretion, and subject to any conditions imposed by the association that do not impair the contractual obligations of the impaired insurer, and that are approved by the commissioner:

(a) Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, any or all of the policies or contracts of the impaired insurer; or

(b) Provide such monies, pledges, loans, notes, guarantees or other means as are proper to effectuate paragraph (a), and assure payment of the contractual obligations of the impaired insurer pending action under paragraph (a).

(2) If a member insurer is an insolvent insurer, the association shall, in its discretion, either:

(a)(i)1. Guarantee, assume, reissue, or reinsure, or cause to be guaranteed, assumed, reissued or reinsured, the policies or contracts of the insolvent insurer; or

2. Assure payment of the contractual obligations of the insolvent insurer; and

(ii) Provide monies, pledges, loans, notes, guarantees or other means reasonably necessary to discharge the association's duties; or

(b) Provide benefits and coverages in accordance with the following provisions:

(i) With respect to policies and contracts, assure payment of benefits that would have been payable under the policies or contracts of the insolvent insurer, for claims incurred:

1. With respect to group policies and contracts, not later than the earlier of the next renewal date under those policies or contracts or forty-five (45) days, but in no event less than thirty (30) days, after the date on which the association becomes obligated with respect to the policies and contracts;

2. With respect to nongroup policies, contracts and annuities not later than the earlier of the next renewal date (if any) under the policies or contracts or one (1) year, but in no event less than thirty (30) days,

from the date on which the association becomes obligated with respect to the policies or contracts;

(ii) Make diligent efforts to provide all known insureds, enrollees or annuitants (for nongroup policies and contracts), or group policy or contract owners with respect to group policies and contracts, thirty (30) days' notice of the termination (pursuant to subparagraph (i) of this paragraph) of the benefits provided;

(iii) With respect to nongroup policies and contracts covered by the association, make available to each known insured, enrollee, or annuitant, or owner if other than the insured, or annuitant, and with respect to an individual formerly an insured, enrollee or annuitant under a group policy or contract who is not eligible for replacement group coverage, make available substitute coverage on an individual basis in accordance with the provisions of subparagraph (iv), if the insureds, enrollees or annuitants had a right under law or the terminated policy, contract or annuity to convert coverage to individual coverage or to continue an individual policy, contract or annuity in force until a specified age or for a specified time, during which the insurer or health maintenance organization had no right unilaterally to make changes in any provision of the policy, contract or annuity or had a right only to make changes in premium by class;

(iv)1. In providing the substitute coverage required under subparagraph (iii), the association may offer either to reissue the terminated coverage or to issue an alternative policy or contract at actuarially justified rates, subject to the prior approval of the commissioner;

2. Alternative or reissued policies or contracts shall be offered without requiring evidence of insurability, and shall not provide for any waiting period or exclusion that would not have applied under the terminated policy or contract;

3. The association may reinsure any alternative or reissued policy or contract;

(v)1. Alternative policies or contracts adopted by the association shall be subject to the approval of the commissioner. The association may adopt alternative policies or contracts of various types for future issuance without regard to any particular impairment or insolvency;

2. Alternative policies or contracts shall contain at least the minimum statutory provisions required in this state and provide benefits that shall not be unreasonable in relation to the premium charged. The association shall set the premium in accordance with a table of rates which it shall adopt. The premium shall reflect the amount of insurance to be provided and the age and class of risk of each insured, but shall not reflect any changes in the health of the insured after the original policy or contract was last underwritten;

3. Any alternative policy or contract issued by the association shall provide coverage of a type similar to that of the policy or contract issued by the impaired or insolvent insurer, as determined by the association;

(vi) If the association elects to reissue terminated coverage at a premium rate different from that charged under the terminated policy or contract, the premium shall be actuarially justified and set by the association in accordance with the amount of insurance or coverage provided and the age and class of risk, subject to prior approval of the commissioner;

(vii) The association's obligations with respect to coverage under any policy or contract of the impaired or insolvent insurer or under any reissued or alternative policy or contract shall cease on the date such coverage or policy or contract is replaced by another similar policy or contract by the policy or contract owner, the insured, the enrollee or the association;

(viii) When proceeding under subsection (2) of this section with respect to any policy or contract carrying guaranteed minimum interest rates, the association shall assure the payment or crediting of a rate of interest consistent with Section 83-23-205(2)(b)(iii).

(3) Nonpayment of premiums within thirty-one (31) days after the date required under the terms of any guaranteed, assumed, alternative or reissued policy or contract or substitute coverage shall terminate the association's obligations under the policy, contract or coverage under this article with respect to the policy, contract or coverage, except with respect to any claims incurred or any net cash surrender value which may be due in accordance with the provisions of this article.

(4) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer shall belong to and be payable at the direction of the association. If the liquidator of an insolvent insurer requests, the association shall provide a report to the liquidator regarding such premium collected by the association. The association shall be liable for unearned premiums due to policy or contract owners arising after the entry of such order.

(5) The protection provided by this article shall not apply where any guaranty protection is provided to residents of this state by the laws of the domiciliary state or jurisdiction of the impaired or insolvent insurer other than this state.

(6) In carrying out its duties under subsection (2) of this section, the association may:

(a) Subject to approval by a court in this state, impose permanent policy or contract liens in connection with a guarantee, assumption or reinsurance agreement, if the association finds that the amounts which can be assessed under this article are less than the amounts needed to assure full and prompt performance of the association's duties under this article, or that the economic or financial conditions as they affect member insurers are sufficiently adverse to render the imposition of such permanent policy or contract liens, to be in the public interest;

(b) Subject to approval by a court in this state, impose temporary moratoriums or liens on payments of cash values and policy loans, or any other right to withdraw funds held in conjunction with policies or contracts, in addition to any contractual provisions for deferral of cash or policy loan value. In addition, in the event of a temporary moratorium or moratorium charge imposed by the receivership court on payment of cash values or policy loans, or on any other right to withdraw funds held in conjunction with policies or contracts, out of the assets of the impaired or insolvent insurer, the association may defer the payment of cash values, policy loans or other rights by the association for a period of the moratorium or moratorium charge imposed by the receivership court, except for claims covered by the association to be paid in accordance with a hardship procedure established by the liquidator or rehabilitator and approved by the receivership court.

(7) A deposit in this state, held pursuant to law or required by the commissioner for the benefit of creditors, including policy or contract owners, not turned over to the domiciliary liquidator upon the entry of a final order of liquidation or order approving a rehabilitation plan of a member insurer domiciled in this state or in a reciprocal state, pursuant to Section 83-24-103 of the Insurers Rehabilitation and Liquidation Act, shall be promptly paid to the association. The association shall be entitled to retain a portion of any amount so paid to it equal to the percentage determined by dividing the aggregate amount of policy or contract owners' claims related to that insolvency for which the association has provided statutory benefits by the aggregate amount of all policy or contract owners' claims in this state related to that insolvency and shall remit to the domiciliary receiver the amount so paid to the association less the amount retained pursuant to this subsection. Any amount so paid to the association and retained by it shall be treated as a distribution of estate assets pursuant to Section 83-24-67 of the Insurers Rehabilitation and Liquidation Act or similar provision of the state of domicile of the impaired or insolvent insurer.

(8) If the association fails to act within a reasonable period of time with respect to an insolvent insurer as provided in subsection (2) of this section, the commissioner shall have the powers and duties of the association under this article with respect to the insolvent insurer.

(9) The association may render assistance and advice to the commissioner, upon the commissioner's request, concerning rehabilitation, payment of claims, continuance of coverage or the performance of other contractual obligations of an impaired or insolvent insurer.

(10) The association shall have standing to appear or intervene before a court or agency in this state with jurisdiction over an impaired or insolvent insurer concerning which the association is or may become obligated under this article or with jurisdiction over any person or property against which the association may have rights through subrogation or otherwise. Standing shall extend to all matters germane to the powers and duties of the association, including, but not limited to, proposals for reinsuring, reissuing, modifying or guaranteeing the policies or contracts of the impaired or insolvent insurer and the determination of the policies or contracts and contractual obligations. The association shall also have the right to appear or intervene before a court or agency in another state with jurisdiction over an impaired or insolvent insurer for which the association is or may become obligated or with jurisdiction over any person or property against whom the association may have rights through subrogation or otherwise.

(11)(a) A person receiving benefits under this article shall be deemed to have assigned the rights under, and any causes of action against any person for losses arising under, resulting from or otherwise relating to, the covered policy or contract to the association to the extent of the benefits received because of this article, whether the benefits are payments of or on account of contractual obligations, continuation of coverage or provision of substitute or alternative policies, contracts or coverages. The association may require an assignment to it of such rights and causes of action by any enrollee, payee, policy or contract owner, beneficiary, insured or annuitant as a condition precedent to the receipt of any right or benefits conferred by this article upon the person.

(b) The subrogation rights of the association under this subsection shall have the same priority against the assets of the impaired or insolvent insurer as that possessed by the person entitled to receive benefits under this article.

(c) In addition to paragraphs (a) and (b) above, the association shall have all common law rights of subrogation and any other equitable or legal remedy that would have been available to the impaired or insolvent insurer or owner, beneficiary, enrollee or payee of a policy or contract with respect to such policy or contracts (including, without limitation, in the case of a structured settlement annuity, any rights of the owner, beneficiary or payee of the annuity, to the extent of benefits received pursuant to this article, against a person originally or by succession responsible for the losses arising from the personal injury relating to the annuity or payment therefore), excepting any such person responsible solely by reason of serving as an assignee in respect of a qualified assignment under Internal Revenue Code Section 130.

(d) If the preceding provisions of this subsection are invalid or ineffective with respect to any person or claim for any reason, the amount payable by the association with respect to the related covered obligations shall be reduced by the amount realized by any other person with respect to the person or claim that is attributable to the policies or contracts (or portion thereof) covered by the association.

(e) If the association has provided benefits with respect to a covered obligation and a person recovers amounts as to which the association has rights as described in the preceding paragraphs of this subsection, the person shall pay to the association the portion of the recovery attributable to the policies or contracts (or portion thereof) covered by the association.

(12) In addition to the rights and powers elsewhere in this article, the association may:

(a) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this article;

(b) Sue or be sued, including taking any legal actions necessary or proper to recover any unpaid assessments under Section 83-23-217 and to settle claims or potential claims against it;

(c) Borrow money to effect the purposes of this article; any notes or other evidence of indebtedness of the association not in default shall be legal investments for domestic insurers and may be carried as admitted assets;

(d) Employ or retain such persons as are necessary or appropriate to handle the financial transactions of the association, and to perform such other functions as become necessary or proper under this article;

(e) Take such legal action as may be necessary or appropriate to avoid or recover payment of improper claims;

(f) Exercise, for the purposes of this article and to the extent approved by the commissioner, the powers of a domestic life insurer, health insurer or health maintenance organization, but in no case may the association issue policies or contracts other than those issued to perform its obligations under this article;

(g) Organize itself as a corporation or in other legal form permitted by the laws of the state;

(h) Request information from a person seeking coverage from the association in order to aid the association in determining its obligations under this article with respect to the person, and the person shall promptly comply with the request;

(i) Unless prohibited by law, in accordance with the terms and conditions of the policy or contract, file for actuarially justified rate or premium increases for any policy or contract for which it provides coverage under this article; and

(j) Take other necessary or appropriate action to discharge its duties and obligations under this article or to exercise its powers under this article.

(13) The association may join an organization of one or more other state associations of similar purposes, to further the purposes and administer the powers and duties of the association.

(14)(a)(i) At any time within one hundred eighty (180) days of the date of the order of liquidation, the association may elect to succeed to the rights and obligations of the ceding member insurer that relate to policies, contracts or annuities covered, in whole or in part, by the association, in each case under any one or more indemnity reinsurance contracts entered into by the insolvent insurer and its reinsurers and selected by the association. Any such assumption shall be effective as of the date of the order of liquidation. The election shall be effected by the association or the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) on its behalf sending written notice, return receipt requested to the affected reinsurers.

(ii) To facilitate the earliest practicable decision about whether to assume any of the contracts of reinsurance, and in order to protect the financial position of the estate, the receiver and each reinsurer of the ceding member insurer shall make available upon request to the association or to NOLHGA on its behalf as soon as possible after commencement of formal delinquency proceedings.

1. Copies of in-force contracts of reinsurance and all related files and records relevant to the determination of whether such contracts should be assumed, and

2. Notices of any defaults under the reinsurance contracts or any known event or condition which with the passage of time could become a default under the reinsurance contracts.

(iii) The following items 1 through 4 shall apply to reinsurance contracts so assumed by the association:

1. The association shall be responsible for all unpaid premiums due under the reinsurance contracts for periods both before and after the date of the order of liquidation, and shall be responsible for the performance of all other obligations to be performed after the date of the order of liquidation, in each case which relate to policies, contracts or annuities covered, in whole or in part, by the association. The association may charge policies, contracts or annuities covered in part by the association, through reasonable allocation methods, the costs for reinsurance in excess of the obligations of the association and shall provide notice and an accounting of these charges to the liquidator;

2. The association shall be entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods after the date of the order of liquidation and that relate to policies, contracts or annuities covered, in whole or in part, by the association provided that, upon receipt of any such amounts, the association shall be obliged to pay to the beneficiary under the policy, contract or annuity on account of which the amounts were paid a portion of the amount equal to the lesser of:

a. The amount received by the association, and

b. The excess of the amount received by the association over the amount equal to the benefits paid by the association on account of the policy, contract or annuity less the retention of the insurer applicable to the loss or event;

3. Within thirty (30) days following the association's election (the "election date"), the association and each reinsurer under contracts assumed by the association shall calculate the net balance due to or from the association under each reinsurance contract as of the election date with respect to policies, contracts or annuities covered, in whole or in part, by the association, which calculation shall give full credit to all items paid by either the member insurer or its receiver or the reinsurer prior to the election date. The reinsurer shall pay the receiver any amounts due for losses or events prior to the date of the order of liquidation, subject to any set-off for premiums unpaid for periods prior to the date, and the association or reinsurer shall pay any remaining balance due the other, in each case within five (5) days of the completion of the aforementioned calculation. Any disputes over the amounts due to either the association or the reinsurer shall be resolved by arbitration pursuant to the terms of the affected reinsurance contracts or, if the contract contains no arbitration clause, as otherwise provided by law. If the receiver has received any amounts due the association pursuant to subparagraph (iii), the receiver shall remit the same to the association as promptly as practicable;

4. If the association or receiver, on the association's behalf, within sixty (60) days of the election date, pays the unpaid premiums due for periods both before and after the election date that relate to policies, contracts or annuities covered, in whole or in part, by the association, the reinsurer shall not be entitled to terminate the reinsurance contracts for failure to pay premium (insofar as the reinsurance contracts) relate to policies, contracts or annuities covered, in whole or in part, by the association and shall not be entitled to set off any unpaid amounts due under other contracts, or unpaid amounts due from parties other than the association against amounts due the association.

(b) During the period from the date of the order of liquidation until the election date (or, if the election date does not occur, until one hundred eighty (180) days after the date of the order of liquidation).

(i)1. Neither the association nor the reinsurer shall have any rights or obligations under reinsurance contracts that the association has the right to assume under paragraph (a), whether for periods prior to or after the date of the order of liquidation; and

2. The reinsurer, the receiver and the association shall, to the extent practicable, provide each other data and record reasonably requested;

(ii) Provided that once the association has elected to assume a reinsurance contract, the parties' rights and obligations shall be governed by paragraph (a).

(c) If the association does not elect to assume a reinsurance contract by the election date pursuant to paragraph (a), the association shall have no rights or obligations, in each case for periods both before and after the date of the order of liquidation, with respect to the reinsurance contract.

(d) When policies, contracts, or annuities, or covered obligations with respect thereto, are transferred to an assuming insurer, reinsurance on the policies, contracts or annuities may also be transferred by the association, in the case of contracts assumed under paragraph (a), subject to the following:

(i) Unless the reinsurer and the assuming insurer agree otherwise, the reinsurance contract transferred shall not cover any new policies of insurance, contracts or annuities in addition to those transferred;

(ii) The obligations described in paragraph (a) of this subsection shall no longer apply with respect to matters arising after the effective date of the transfer; and

(iii) Notice shall be given in writing, return receipt requested, by the transferring party to the affected reinsurer not less than thirty (30) days prior to the effective date of the transfer.

(e) The provisions of this subsection shall supersede the provisions of any law or of any affected reinsurance contract that provides for or requires any payment of reinsurance proceeds, on account of losses or events that occur in periods after the date of the order of liquidation, to the receiver of the insolvent insurer or any other person. The receiver shall remain entitled to any amounts payable by the reinsurer under the reinsurance contracts with respect to losses or events that occur in periods prior to the date of the order of liquidation (subject to applicable setoff provisions).

(f) Except as otherwise provided in this subsection, nothing in this subsection shall alter or modify the terms and conditions of any reinsurance contract. Nothing in this subsection shall abrogate or limit any rights of any reinsurer to claim that it is entitled to rescind a reinsurance contract. Nothing in this subsection shall give a policyholder, contract owner, enrollee, certificate holder or beneficiary an independent cause of action against a reinsurer that is not otherwise set forth in the reinsurance contract. Nothing in this subsection shall limit or affect the association's rights as a creditor of the estate against the assets of the estate. Nothing in this subsection shall apply to reinsurance agreements covering property or casualty risks.

(15) The board of directors of the association shall have discretion and may exercise a reasonable business judgment to determine the means by which the association is to provide the benefits of this article in an economical and efficient manner.

(16) Where the association has arranged or offered to provide the benefits of this article to a covered person under a plan or arrangement that fulfills the association's obligations under this article, the person shall not be entitled to benefits from the association in addition to or other than those provided under the plan or arrangement.

(17) Venue in a suit against the association arising under the article shall be in Hinds County, Mississippi. The association shall not be required to give an appeal bond in an appeal that relates to a cause of action arising under this article.

(18) In carrying out its duties in connection with guaranteeing, assuming, reissuing, or reinsuring policies or contracts under subsections (1) and (2) of this section, the association may issue substitute coverage for a policy or contract that provides an interest rate, crediting rate or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value by issuing an alternative policy or contract in accordance with the following provisions:

(a) In lieu of the index or other external reference provided for in the original policy or contract, the alternative policy or contract provides for (i) a fixed interest rate or (ii) payment of dividends with minimum guarantees or (iii) a different method for calculating interest or changes in value;

(b) There is no requirement for evidence of insurability, waiting period or other exclusion that would not have applied under the replaced policy or contract; and

(c) The alternative policy or contract is substantially similar to the replaced policy or contract in all other material terms.

HISTORY: Laws, 1985, ch. 482, § 8; Laws, 1990, ch. 546, § 5; Laws, 1999, ch. 365, § 5; Laws, 2014, ch. 358, § 3, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 5, eff from and after July 1, 2020.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected an error in a statutory reference in the introductory paragraph of (18) by substituting "subsections (1) and (2) of this section" for "Section 83-23-215(1) and (2)." The Joint Committee ratified the correction at its July 24, 2014, meeting.

Cross References — Insolvent insurance companies, see §§ 83-23-1 et seq.

Definition of "impaired insurer," see § 83-23-209.

Assessments against member insurers, see § 83-23-217.

Use of class "B" assessments to carry out duties of association with respect to impaired or insolvent insurers, see § 83-23-217.

Association's plan of operation, see § 83-23-219.

Duties of commissioner, see § 83-23-221.

Reduction in liability of insolvent insurer to association by amount to which association is entitled as subrogee under § 83-23-215, see § 83-23-225.

Requirement that records be kept of negotiations between association and insolvent or impaired insurers, see § 83-23-225.

Annual report by association, see § 83-23-227.

Immunity of association, commissioner, and their agents and employees, see § 83-23-231.

Entitlement of association to stay of actions involving insolvent insurers, see § 83-23-233.

Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

Federal Aspects— Sections 130 of the Internal Revenue Code, see 26 USCS § 130.

JUDICIAL DECISIONS

1. In general.

Mississippi Life and Health Insurance Guaranty Association is liable to insured covered by insolvent health insurer only for contractual obligation of insurer, not for attorney fees and punitive damages included in default judgment against insolvent insurer. Rowley v. First Columbia Life Ins. Co., 741 F. Supp. 1259, 1989 U.S. Dist. LEXIS 16991 (S.D. Miss. 1989).

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.

44 C.J.S., Insurance § 197.

§ 83-23-217. Assessments against member insurers; classes; refunds; treatment of assessments on financial statements of member insurers; protest of assessment.

(1) For the purpose of providing the funds necessary to carry out the powers and duties of the association, the board of directors shall assess the member insurers, separately for each account, at such time and for such amounts as the board finds necessary. Assessments shall be due not less than thirty (30) days after prior written notice to the member insurers and shall accrue interest at twelve percent (12%) per annum on and after the due date.

(2) There shall be two (2) classes of assessments, as follows:

(a) Class A assessments shall be authorized and called for the purpose of meeting administrative and legal costs and other expenses. Class A assessments may be authorized and called whether or not related to a particular impaired or insolvent insurer.

(b) Class B assessments shall be authorized and called to the extent necessary to carry out the powers and duties of the association under Section 83-23-215 with regard to an impaired or insolvent insurer.

(3)(a) The amount of a Class A assessment shall be determined by the board and may be authorized and called on a pro rata or nonpro rata basis. If pro rata, the board may provide that it be credited against future Class B assessments. The total of all nonpro rata assessments shall not exceed Five Hundred Dollars ($500.00) per member insurer in any one (1) calendar year.

(b) The amount of a Class B assessment, except for assessments related to long-term care insurance, shall be allocated for assessment purposes between the accounts and among the subaccounts of the life insurance and annuity account, pursuant to an allocation formula which may be based on the premiums or reserves of the impaired or insolvent insurer or any other standard deemed by the board in its sole discretion as being fair and reasonable under the circumstances.

(c) The amount of the Class B assessment for long-term care insurance written by the impaired or insolvent insurer shall be allocated according to a methodology included in the plan of operation and approved by the commissioner. The methodology shall provide for fifty percent (50%) of the assessment to be allocated to accident and health member insurers and fifty percent (50%) to be allocated to life and annuity member insurers.

(d) Class B assessments against member insurers for each account and subaccount shall be in the proportion that the premiums received on business in this state by each assessed member insurer on policies or contracts covered by each account for the three (3) most recent calendar years for which information is available preceding the year in which the member insurer became insolvent (or, in the case of an assessment with respect to an impaired insurer, the three (3) most recent calendar years for which information is available preceding the year in which the member insurer became impaired) bears to premiums received on business in this state for those calendar years by all assessed member insurers.

(e) Assessments for funds to meet the requirements of the association with respect to an impaired or insolvent insurer shall not be authorized or called until necessary to implement the purposes of this article. Classification of assessments under subsection (2) and computation of assessments under this subsection shall be made with a reasonable degree of accuracy, recognizing that exact determinations may not always be possible. The association shall notify each member insurer of its anticipated pro rata share of an authorized assessment not yet called within one hundred eighty (180) days after the assessment is authorized.

(4) The association may abate or defer, in whole or in part, the assessment of a member insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the member insurer to fulfill its contractual obligations. In the event an assessment against a member insurer is abated, or

deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other member insurers in a manner consistent with the basis for assessments set forth in this section. Once the conditions that caused a deferral have been removed or rectified, the member insurer shall pay all assessments that were deferred pursuant to a repayment plan approved by the association.

(5)(a)(i) Subject to the provisions of subparagraph (ii) of this paragraph, the total of all assessments authorized by the association with respect to a member insurer for each subaccount of the life insurance and annuity account and for the health account shall not in one (1) calendar year exceed two percent (2%) of that member insurer's average annual premiums received in this state on the policies and contracts covered by the subaccount or account during the three (3) calendar years preceding the year in which the member insurer became an impaired or insolvent insurer.

(ii) If two (2) or more assessments are authorized in one (1) calendar year with respect to member insurers that become impaired or insolvent in different calendar years, the average annual premiums for purposes of the aggregate assessment percentage limitation referenced in subparagraph (i) of this paragraph shall be equal and limited to the higher of the three-year average annual premiums for the applicable subaccount or account as calculated pursuant to this section.

(iii) If the maximum assessment, together with the other assets of the association in an account, does not provide in one (1) year in either account an amount sufficient to carry out the responsibilities of the association, the necessary additional funds shall be assessed as soon thereafter as permitted by this article.

(b) The board may provide in the plan of operation a method of allocating funds among claims, whether relating to one or more impaired or insolvent insurers, when the maximum assessment will be insufficient to cover anticipated claims.

(c) If the maximum assessment for a subaccount of the life and annuity account in one (1) year does not provide an amount sufficient to carry out the responsibilities of the association, then pursuant to subsection (3)(b) of this section, the board shall assess the other subaccounts of the life and annuity account for the necessary additional amount, subject to the maximum stated in subsection (5)(a) above.

(6) The board may, by an equitable method as established in the plan of operation, refund to member insurers, in proportion to the contribution of each member insurer to that account, the amount by which the assets of the account exceed the amount the board finds is necessary to carry out during the coming year the obligations of the association with regard to the account, including assets accruing from assignment, subrogation, net realized gains and income from investments. A reasonable amount may be retained in any account to provide funds for the continuing expenses of the association and for future losses claims.

(7) It shall be proper for any member insurer, in determining its premium rates and policy owner dividends as to any kind of insurance or health maintenance organization business within the scope of this article, to consider the amount reasonably necessary to meet its assessment obligations under this article.

(8) The association shall issue to each member insurer paying an assessment under this article, other than a Class A assessment, a certificate of contribution, in a form prescribed by the commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of equal dignity and priority without reference to amounts or dates of issue. A certificate of contribution may be shown by the member insurer in its financial statement as an asset in such form and for such amount, if any, and period of time as the commissioner may approve.

(9)(a) A member insurer that wishes to protest all or part of an assessment shall pay when due the full amount of the assessment as set forth in the notice provided by the association. The payment shall be available to meet association obligations during the pendency of the protest or any subsequent appeal. Payment shall be accompanied by a statement in writing that the payment is made under protest and setting forth a brief statement of the grounds for the protest.

(b) Within sixty (60) days following the payment of an assessment under protest by a member insurer, the association shall notify the member insurer in writing of its determination with respect to the protest unless the association notifies the member insurer that additional time is required to resolve the issues raised by the protest.

(c) Within thirty (30) days after a final decision has been made, the association shall notify the protesting member insurer in writing of that final decision. Within sixty (60) days of receipt of notice of the final decision, the protesting member insurer may appeal that final action to the commissioner.

(d) In the alternative to rendering a final decision with respect to a protest based on a question regarding the assessment base, the association may refer protests to the commissioner for a final decision, with or without a recommendation from the association.

(e) If the protest or appeal on the assessment is upheld, the amount paid in error or excess shall be returned to the member insurer. Interest on a refund due a protesting member insurer shall be paid at the rate actually earned by the association.

(10) The association may request information of member insurers in order to aid in the exercise of its power under this section and member insurers shall promptly comply with a request.

HISTORY: Laws, 1985, ch. 482, § 9; Laws, 1990, ch. 546, § 6; Laws, 1999, ch. 365, § 6; Laws, 2014, ch. 358, § 4, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 6, eff from and after July 1, 2020.

Cross References — Definition of "premiums" see § 83-23-209.
Association's duties with respect to impaired or insolvent insurers, see § 83-23-215.
Offset of assessment amounts against taxes, see § 83-23-218.
Association's plan of operation, see § 83-23-219.
Duties of commissioner, see § 83-23-221.
Examinations conducted by association to prevent insolvencies, see § 83-23-223.
Liability of insolvent or impaired insurer for assessments, see § 83-23-225.

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.

44 C.J.S., Insurance § 197.

§ 83-23-218. Member insurers permitted to offset assessment against taxes.

(1) From and after July 1, 1993, a member insurer may offset against its (premium, franchise or income) tax liability (or liabilities) to this state an assessment described in Section 83-23-217(8) to the extent of twenty percent (20%) of the amount of such assessment, if any, for each year over the next five (5) succeeding years. However, if the offset is less than twenty percent (20%), any unused balance may be carried over to any succeeding year until such time as the offset provided herein is fully used. In the event a member insurer should cease doing business, all uncredited assessments may be credited against its (premium, franchise or income) tax liability (or liabilities) for the year it ceases doing business.

(2) Any sums which are acquired by refund, pursuant to Section 83-23-217(6), from the association by member insurers, and which have theretofore been offset against (premium, franchise or income) taxes as provided in subsection (1) of this section, shall be paid by such insurers to this state in such manner as the tax authorities may require. The association shall notify the commissioner that such refunds have been made.

HISTORY: Laws, 1990, ch. 546, § 11; Laws, 1993, ch. 347, § 1, eff from and after July 1, 1993.

§ 83-23-219. Plan of operation; approval by commissioner; contents of plan.

(1)(a) The association shall submit to the commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the association. The plan of operation and any amendments thereto shall become effective upon the commissioner's written approval or unless it has not been disapproved within thirty (30) days.

(b) If the association fails to submit a suitable plan of operation within one hundred eighty (180) days following April 9, 1985, or if at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this article. Such rules shall continue in force until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner.

(2) All member insurers shall comply with the plan of operation.

(3) The plan of operation shall, in addition to requirements enumerated elsewhere in this article:

(a) Establish procedures for handling the assets of the association;

(b) Establish the amount and method of reimbursing members of the board of directors under Section 83-23-213;

(c) Establish regular places and times for meetings including telephone conference calls of the board of directors;

(d) Establish procedures for records to be kept of all financial transactions of the association, its agents and the board of directors;

(e) Establish the procedures whereby selections for the board of directors will be made and submitted to the commissioner;

(f) Establish any additional procedures for assessments under Section 83-23-217;

(g) Contain additional provisions necessary or proper for the execution of the powers and duties of the association;

(h) Establish procedures whereby a director may be removed for cause, including in the case where a member insurer director becomes an impaired or insolvent insurer;

(i) Require the board of directors to establish a policy and procedures for addressing conflicts of interests.

(4) The plan of operation may provide that any or all powers and duties of the association, except those under Sections 83-23-215 and 83-23-217, are delegated to a corporation, association or other organization which performs or will perform functions similar to those of this association, or its equivalent, in two (2) or more states. Such a corporation, association or organization shall be reimbursed for any payments made on behalf of the association and shall be paid for its performance of any function of the association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the commissioner, and may be made only to a corporation, association or organization which extends protection not substantially less favorable and effective than that provided by this article.

HISTORY: Laws, 1985, ch. 482, § 10; Laws, 1990, ch. 546, § 7; Laws, 2014, ch. 358, § 5, eff from and after passage (approved Mar. 17, 2014).

Cross References — Requirement that association perform its functions under plan of operation, see § 83-23-211.

Board of directors of association, see § 83-23-213.

Powers of association, see § 83-23-215.

Assessments, see § 83-23-217.

Duties of commissioner, see § 83-23-221.

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.

44 C.J.S., Insurance § 197.

§ 83-23-221. Duties of commissioner; enforcement of assessments against member insurers; appeal.

(1) In addition to the duties and powers enumerated elsewhere in this article, the commissioner shall:

(a) Upon request of the board of directors, provide the association with a statement of the premiums in this and any other appropriate states for each member insurer; and

(b) When an impairment is declared and the amount of the impairment is determined, serve a demand upon the impaired insurer to make good the impairment within a reasonable time; notice to the impaired insurer shall constitute notice to its shareholders, if any; the failure of the impaired insurer to promptly comply with such demand shall not excuse the association from the performance of its powers and duties under this article.

(2) The commissioner may suspend or revoke, after notice and hearing, the certificate of authority to transact business in this state of any member insurer which fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative the commissioner may levy a forfeiture on any member insurer which fails to pay an assessment when due. The forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but no forfeiture shall be less than One Hundred Dollars ($100.00) per month.

(3) A final action of the board of directors or the association may be appealed to the commissioner by a member insurer if the appeal is taken within sixty (60) days of its receipt of notice of the final action being appealed. A final action or order of the commissioner shall be subject to judicial review in a court of competent jurisdiction in accordance with the laws of this state that apply to the actions or orders of the commissioner.

(4) The liquidator, rehabilitator or conservator of an impaired or insolvent insurer may notify all interested persons of the effect of this article.

HISTORY: Laws, 1985, ch. 482, § 11; Laws, 1990, ch. 546, § 8; Laws, 1999, ch. 365, § 7; Laws, 2014, ch. 358, § 6, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 7, eff from and after July 1, 2020.

Cross References — Commissioner's power to order insurer to discontinue certain investment practices, see § 83-19-51.

Commissioner's duties with respect to insolvent insurers, see §§ 83-23-1 et seq.

Commissioner's approval of members of board of directors, see § 83-23-213.

Commissioner's approval of plans to guaranty obligations of impaired or insolvent insurers, see § 83-23-215.

Commissioner's approval of member insurer's method of carrying assessment on its financial statements, see § 83-23-217.

Notice by commissioner of actions against member insurers, see § 83-23-223.

Examination by commissioner of association, see § 83-23-227.

Immunity of association, commissioner, and their agents and employees, see § 83-23-231.

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 115 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance § 197.

§ 83-23-223. Detection and prevention of member insurer insolvencies or impairments.

To aid in the detection and prevention of member insurer insolvencies or impairments:

(1) It shall be the duty of the commissioner;

(a) To notify the commissioners of all the other states, territories of the United States and the District of Columbia within thirty (30) days following the action taken or the date the action occurs, when the commissioner takes any of the following actions against a member insurer:

(i) Revocation of license;

(ii) Suspension of license; or

(iii) Makes a formal order that the member insurer restrict its premium writing, obtain additional contributions to surplus, withdraw from the state, reinsure all or any part of its business, or increase capital, surplus or any other account for the security of policy owners, contract owners, certificate holders or creditors.

(b) To report to the board of directors when the commissioner has taken any of the actions set forth in subparagraph (a) or has received a report from any other commissioner indicating that any such action has been taken in another state. The report to the board of directors shall contain all significant details of the action taken or the report received from another commissioner.

(c) To report to the board of directors when the commissioner has reasonable cause to believe from an examination, whether completed or in process, of any member insurer that the insurer may be an impaired or insolvent insurer.

(d) To furnish to the board of directors the NAIC Insurance Regulatory Information System (IRIS) ratios and listings of companies not included in the ratios developed by the National Association of Insurance Commissioners, and the board may use the information contained therein in carrying out its duties and responsibilities under this section. The report and the information contained therein shall be kept confidential by the board of directors until such time as made public by the commissioner or other lawful authority.

(2) The commissioner may seek the advice and recommendations of the board of directors concerning any matter affecting the duties and responsibilities of the commissioner regarding the financial condition of member insurers and insurers or health maintenance organizations seeking admission to transact business in this state.

(3) The board of directors may, upon majority vote, make reports and recommendations to the commissioner upon any matter germane to the solvency, liquidation, rehabilitation or conservation of any member insurer or germane to the solvency of any insurer or health maintenance organization seeking to do business in this state. The reports and recommendations shall not be considered public documents.

(4) The board of directors may, upon majority vote, notify the commissioner of any information indicating a member insurer may be an impaired or insolvent insurer.

(5) The board of directors may, upon majority vote, make recommendations to the commissioner for the detection and prevention of member insurer insolvencies.

HISTORY: Laws, 1985, ch. 482, § 12; Laws, 1999, ch. 365, § 8; Laws, 2014, ch. 358, § 7, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 8, eff from and after July 1, 2020.

Cross References — Board of directors, see § 83-23-213.

Fund to be used for costs of examination of member insurer, see § 83-23-217.

Duties of commissioner, generally, see § 83-23-221.

Immunity of association, commissioner, and their agents and employees, see § 83-23-231.

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.

44 C.J.S., Insurance § 197.

§ 83-23-225. Liability of insolvent or impaired insurer for assessments.

(1) This article shall not be construed to reduce the liability for unpaid assessments of the insureds of an impaired or insolvent insurer operating under a plan with assessment liability.

(2) Records shall be kept of all meetings of the board of directors to discuss the activities of the association in carrying out its powers and duties under Section 83-23-215. The records of the association with respect to an impaired or insolvent insurer shall not be disclosed prior to the termination of a liquidation, rehabilitation or conservation proceeding involving the impaired or insolvent insurer, except (a) upon the termination of the impairment or insolvency of the member insurer, or (b) upon the order of a court of competent jurisdiction. Nothing in this subsection shall limit the duty of the association to render a report of its activities under Section 83-23-227.

(3) For the purpose of carrying out its obligations under this article, the association shall be deemed to be a creditor of the impaired or insolvent insurer to the extent of assets attributable to covered policies reduced by any amounts to which the association is entitled as subrogee pursuant to Section 83-23-215(11). Assets of the impaired or insolvent insurer attributable to covered policies shall be used to continue all covered policies and pay all contractual obligations of the impaired or insolvent insurer as required by this article. Assets attributable to covered policies, as used in this subsection, are that proportion of the assets which the reserves that should have been established for such policies or contracts bear to the reserves that should have been established for all policies of insurance or health benefit plans written by the impaired or insolvent insurer.

(4) As a creditor of the impaired or insolvent insurer as established in subsection (3) of this section and consistent with Section 83-24-67, the association and other similar associations shall be entitled to receive a disbursement of assets out of the marshaled assets, from time to time as the assets become available to reimburse it, as a credit against contractual obligations under this article. If the liquidator has not, within one hundred twenty (120) days of a final determination of insolvency of a member insurer by the receivership court, made an application to the court for the approval of a proposal to disburse assets out of marshaled assets to guaranty associations having obligations because of the insolvency, then the association shall be entitled to make application to the receivership court for approval of its own proposal to disburse these assets.

(5)(a) Prior to the termination of any liquidation, rehabilitation or conservation proceeding, the court may take into consideration the contributions of the respective parties, including the association, the shareholders, contract owners, certificate holders, enrollees and policy owners of the insolvent insurer, and any other party with a bona fide interest, in making an equitable distribution of the ownership rights of the insolvent insurer. In such a determination, consideration shall be given to the welfare of the policy owners, contract owners, certificate holders and enrollees of the continuing or successor member insurer.

(b) No distribution to stockholders, if any, of an impaired or insolvent insurer shall be made until and unless the total amount of valid claims of the association with interest thereon for funds expended in carrying out its powers and duties under Section 83-23-215 with respect to the member insurer have been fully recovered by the association.

(6)(a) If an order for liquidation or rehabilitation of a member insurer domiciled in this state has been entered, the receiver appointed under the order shall have a right to recover on behalf of the member insurer, from any affiliate that controlled it, the amount of distributions, other than stock dividends paid by the member insurer on its capital stock, made at any time during the five (5) years preceding the petition for liquidation or rehabilitation subject to the limitations of paragraphs (b) through (d).

(b) No such distribution shall be recoverable if the member insurer shows that when paid the distribution was lawful and reasonable, and that the member insurer did not know and could not reasonably have known that the distribution might adversely affect the ability of the member insurer to fulfill its contractual obligations.

(c) Any person who was an affiliate that controlled the member insurer at the time the distributions were paid shall be liable up to the amount of distributions received. Any person who was an affiliate that controlled the member insurer at the time the distributions were declared, shall be liable up to the amount of distributions which would have been received if they had been paid immediately. If two (2) or more persons are liable with respect to the same distributions, they shall be jointly and severally liable.

(d) The maximum amount recoverable under this subsection shall be the amount needed in excess of all other available assets of the insolvent insurer to pay the contractual obligations of the insolvent insurer.

(e) If any person liable under paragraph (c) is insolvent, all its affiliates that controlled it at the time the distribution was paid, shall be jointly and severally liable for any resulting deficiency in the amount recovered from the insolvent affiliate.

HISTORY: Laws, 1985, ch. 482, § 13; Laws, 1990, ch. 546, § 9; Laws, 1999, ch. 365, § 9; Laws, 2014, ch. 358, § 8, eff from and after passage (approved Mar. 17, 2014); Laws, 2020, ch. 304, § 9, eff from and after July 1, 2020.

Cross References — Powers of association, see § 83-23-215.
Assessments by association, see § 83-23-217.
Annual report of association's activities, see § 83-23-227.

RESEARCH REFERENCES

ALR.
Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.
What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.
44 C.J.S., Insurance § 197.

§ 83-23-227. Regulation by commissioner; annual report.

The association shall be subject to examination and regulation by the commissioner. The board of directors shall submit to the commissioner, each year not later than one hundred twenty (120) days after the association's fiscal year, a financial report in a form approved by the commissioner and a report of its activities during the preceding fiscal year. Upon the request of a member insurer, the association shall provide the member insurer with a copy of the report.

HISTORY: Laws, 1985, ch. 482, § 14; Laws, 2014, ch. 358, § 9, eff from and after passage (approved Mar. 17, 2014).

Cross References — Powers of association, see § 83-23-215.
Duties of commissioner, see § 83-23-221.
Records of negotiations with insolvent or impaired insurers, see § 83-23-225.

RESEARCH REFERENCES

ALR.
Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.
What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.
44 C.J.S., Insurance § 197.

§ 83-23-229. Tax status of association.

The association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions, except taxes levied on real property.

HISTORY: Laws, 1985, ch. 482, § 15, eff from and after passage (approved April 9, 1985).

RESEARCH REFERENCES

ALR.
Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.
What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.
44 C.J.S., Insurance § 197.

§ 83-23-231. Immunity of member insurers, employees, directors of association and similar organizations.

There shall be no liability on the part of and no cause of action of any nature shall arise against any member insurer or its agents or employees, the association or its agents or employees, members of the board of directors, or the commissioner or his representatives, for any action or omission by them in the performance of their powers and duties under this article. Such immunity shall extend to the participation in any organization of one or more other state associations of similar purposes and to any such organization and its agents or employees.

HISTORY: Laws, 1985, ch. 482, § 16; Laws, 1990, ch. 546, § 10, eff from and after July 1, 1990.

JUDICIAL DECISIONS

1. Liability for misrepresentation.

Insured couple's misrepresentation claims against the life insurance company that purchased the assets of an insolvent insurer from whom the couple had purchased their policies failed because the company assumed no liability caused by any alleged fraudulent misrepresentations or omissions of the insurer or its agents; the company had not assumed any obligations other than the covered obligations and the policy unequivocally stated premiums were due for life. Gregory v. Cent. Sec. Life Ins. Co., 953 So. 2d 233, 2007 Miss. LEXIS 205 (Miss. 2007).

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.

44 C.J.S., Insurance § 197.

§ 83-23-233. Stay of judicial proceedings upon order of liquidation, rehabilitation, or conservation.

All proceedings in which the insolvent insurer is a party in any court in this state shall be stayed one hundred and eighty (180) days from the date an order of liquidation, rehabilitation or conservation is final to permit proper legal action by the association on any matters germane to its powers or duties. As to judgment under any decision, order, verdict or finding based on default the association may apply to have such judgment set aside by the same court that made such judgment and shall be permitted to defend against such suit on the merits.

HISTORY: Laws, 1985, ch. 482, § 17; Laws, 2014, ch. 358, § 10, eff from and after passage (approved Mar. 17, 2014).

Cross References — Proceedings involving insolvent insurance companies, see §§ 83-23-1 et seq.

Powers of association, see § 83-23-215.

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.
44 C.J.S., Insurance § 197.

§ 83-23-235. Use of association's name in insurance advertisements or solicitations; association to prepare document describing general purposes and limitations of association.

(1) No person, including a member insurer, agent or affiliate of a member insurer shall make, publish, disseminate, circulate or place before the public, or cause directly or indirectly, to be made, published, disseminated, circulated or placed before the public, in any newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio station or television station, or in any other way, any advertisement, announcement or statement, written or oral, which uses the existence of the Insurance Guaranty Association of this state for the purpose of sales, solicitation or inducement to purchase any form of insurance or other coverage covered by the Mississippi Life and Health Insurance Guaranty Association Act. However, this section shall not apply to the Mississippi Life and Health Insurance Guaranty Association or any other entity which does not sell or solicit insurance or coverage by a health maintenance organization.

(2) Within one hundred eighty (180) days of April 9, 1985, the association shall prepare a summary document describing the general purposes and current limitations of the article and complying with subsection (3) of this section. This document shall be submitted to the commissioner for approval. At the expiration of the sixtieth day after the date on which the commissioner approves the document, a member insurer may not deliver a policy or contract to a policy owner, contract owner, certificate holder or enrollee unless the summary document is delivered to the policy owner, contract owner, certificate holder or enrollee at the time of delivery of the policy or contract. The document shall also be available upon request by a policy owner, contract owner, certificate holder or enrollee. The distribution, delivery or contents or interpretation of this document does not guarantee that either the policy or the contract or the policy owner, contract owner, certificate holder or enrollee is covered in the event of the impairment or insolvency of a member insurer. The description document shall be revised by the association as amendments to the article may require. Failure to receive this document does not give the policy owner, contract owner, certificate holder, enrollee or insured any greater rights than those stated in this article.

(3) The document prepared under subsection (2) shall contain a clear and conspicuous disclaimer on its face. The commissioner shall establish the form and content of the disclaimer. The disclaimer shall:

(a) State the name and address of the Life and Health Insurance Guaranty Association and insurance department;

(b) Prominently warn the policy owner, contract owner, certificate holder or enrollee that the Life and Health Insurance Guaranty Association may not cover the policy or contract or, if coverage is available, it will be subject to substantial limitations and exclusions and conditioned on continued residence in this state;

(c) State the types of policies or contracts for which guaranty funds will provide coverage;

(d) State that the member insurer and its agents are prohibited by law from using the existence of the Life and Health Insurance Guaranty Association for the purpose of sales, solicitation or inducement to purchase any form of insurance or health maintenance organization coverage;

(e) State that the policy owner, contract owner, certificate holder or enrollee should not rely on coverage under the Life and Health Insurance Guaranty Association when selecting an insurer or health maintenance organization;

(f) Explain rights available and procedures for filing a complaint to allege a violation of any provisions of this article; and

(g) Provide other information as directed by the commissioner including, but not limited to, sources for information about the financial condition of insurers provided that the information is not proprietary and is subject to disclosure under that state's public records law.

(4) A member insurer shall retain evidence of compliance with subsection (2) for so long as the policy or contract for which the notice is given remains in effect.

HISTORY: Laws, 1985, ch. 482, § 18; Laws, 1999, ch. 365, § 10, eff from and after passage (approved Mar. 15, 1999); Laws, 2020, ch. 304, § 10, eff from and after July 1, 2020.

Cross References — Unfair deceptive insurance practices, see § 83-5-35.

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 115 et seq.

CJS.

44 C.J.S., Insurance § 197.

§ 83-23-237. Applicability of amendments by Chapter 358, Laws of 2014.

The amendments made to this article by Chapter 358, Laws of 2014 during the 2014 Regular Session of the Legislature shall not apply to any member insurer that, before March 17, 2014, has been placed under an order of liquidation with a finding of insolvency.

HISTORY: Laws, 2014, ch. 358, § 11, eff from and after passage (approved Mar. 17, 2014).

Editor's Notes — Chapter 358, Laws of 2014, amended the following: Sections 83-23-205, 83-23-209, 83-23-215, 83-23-217, 83-23-219, 83-23-221, 83-23-223, 83-23-225, 83-23-227, 83-23-233, and 83-23-239.

§ 83-23-239. Amendments by Chapter 304, Laws of 2020, to this article not applicable to member insurers placed under liquidation order.

The amendments made to this article by Chapter 304, Laws of 2020, shall not apply to any member insurer that, before the effective date of those amendments, has been placed under an order of liquidation with a finding of insolvency.

HISTORY: Laws, 2020, ch. 304, § 11, eff from and after July 1, 2020.

Editor's Notes — Laws of 2020, Chapter 304, amended Miss. Code Ann. § 83-23-203, Miss. Code Ann. § 83-23-205, Miss. Code Ann. § 83-23-209, Miss. Code Ann. § 83-23-211, Miss. Code Ann. § 83-23-215, Miss. Code Ann. § 83-23-217, Miss. Code Ann. § 83-23-221, Miss. Code Ann. § 83-23-223, Miss. Code Ann. § 83-23-225, and Miss. Code Ann. § 83-23-235.

CHAPTER 24.

INSURERS REHABILITATION AND LIQUIDATION ACT

Sec.

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83-24-117. Failure of ancillary receiver in another state or foreign country to transfer assets to domiciliary liquidator.

§ 83-24-1. Short title.

This chapter shall be cited as the Insurers Rehabilitation and Liquidation Act.

HISTORY: Laws, 1991, ch. 417, § 1, eff from and after passage (approved March 20, 1991).

Cross References — Maintenance of civil action for damages for benefit of insurer, if order for liquidation or rehabilitation of controlled insurer entered in accordance with this (Insurers Rehabilitation and Liquidation) Act, see § 83-59-11.

RESEARCH REFERENCES

ALR.

Validity, construction, and application of Uniform Insurers Liquidation Act. 44 A.L.R.5th 683.

§ 83-24-3. Declaration of purpose.

The purpose of this chapter is the protection of the interests of insureds, claimants, creditors and the public generally; with minimum interference with the normal prerogatives of the owners and managers of insurers, through:

(a) Early detection of any potentially dangerous condition in an insurer, and prompt application of appropriate corrective measures;

(b) Improved methods for rehabilitating insurers, involving the cooperation and management expertise of the insurance industry;

(c) Enhanced efficiency and economy of liquidation, through clarification of the law, to minimize legal uncertainty and litigation;

(d) Equitable apportionment of any unavoidable loss;

(e) Lessening the problems of interstate rehabilitation and liquidation by facilitating cooperation between states in the liquidation process, and by extending the scope of personal jurisdiction over debtors of the insurer outside this state;

(f) Regulation of the insurance business by the impact of the law relating to delinquency procedures and substantive rules on the entire insurance business; and

(g) Providing for a comprehensive scheme for the rehabilitation and liquidation of insurance companies and those subject to this chapter as part of the regulation of the business of insurance, insurance industry and insurers in this state. Proceedings in cases of insurer insolvency and delinquency are deemed an integral aspect of the business of insurance and are of vital public interest and concern.

HISTORY: Laws, 1991, ch. 417, § 2, eff from and after passage (approved March 20, 1991).

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of Uniform Insurers Liquidation Act. 46 A.L.R.2d 1185.

What constitutes insolvency of insurance company justifying state dissolution proceedings and the like. 17 A.L.R.4th 16.

Validity, construction, and effect of statute establishing compensation for claims not paid because of insurer's insolvency. 30 A.L.R.4th 1110.

Primary insurer's insolvency as affecting excess insurer's liability. 85 A.L.R.4th 729.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 93-118 (insolvency, dissolution, and rehabilitation).
14 Am. Jur. Pl & Pr Forms (Rev), Insolvency, Form 1.
14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 42.
10 Am. Jur. Legal Forms 2d, Insolvency § 148:1.
3 Am. Jur. Trials 681, Tactics and Strategy of Pleading.
6 Am. Jur. Proof of Facts 367, Insolvency, Proof 2.

CJS.
44 C.J.S., Insurance §§ 181-197.

§ 83-24-5. Application of chapter.

The proceedings authorized by this chapter may be applied to:

(a) All insurers who are doing, or have done, an insurance business in this state, and against whom claims arising from that business may exist now or in the future.

(b) All insurers who purport to do an insurance business in this state.

(c) All insurers who have insureds residing in this state.

(d) All other persons organized or in the process of organizing with the intent to do an insurance business in this state.

(e) All nonprofit service plans and all fraternal benefit societies and beneficial societies.

(f) All title insurance companies.

(g) All prepaid health care delivery plans.

(h) All corporate bodies organized for the purpose of carrying on the business of mutual insurance subject to the provisions of Section 83-31-1 et seq.

(i) All health maintenance organizations established under Section 41-7-401.

HISTORY: Laws, 1991, ch. 417, § 3; Laws, 1994, ch. 422, § 2; Laws, 1997, ch. 307, § 5, eff from and after July 1, 1997.

Editor's Notes — Section 41-7-401 referred to in (i) was repealed by Laws of 1998, ch. 613, § 35, eff from and after July 1, 1995. For similar provisions, see §§ 83-41-301 et seq.

Cross References — "Doing business" defined, see § 83-24-7.
Fraternal benefit societies defined, see § 83-29-1.
Applicability of this chapter to health maintenance organizations, see § 83-41-341.

§ 83-24-7. Definitions.

For the purposes of this chapter:

(a) "Ancillary state" means any state other than a domiciliary state.

(b) "Commissioner" means the Commissioner of Insurance.

(c) "Creditor" is a person having any claim, whether matured or unmatured, liquidated or unliquidated, secured or unsecured, absolute, fixed or contingent.

(d) "Delinquency proceeding" means any proceeding instituted against an insurer for the purpose of liquidating, rehabilitating, reorganizing or conserving such insurer, and any summary proceeding under Section 83-24-19. "Formal delinquency proceeding" means any liquidation or rehabilitation proceeding.

(e) "Doing business" includes any of the following acts, whether effected by mail or otherwise:

(i) The issuance or delivery of contracts of insurance to persons residing in this state;

(ii) The solicitation of applications for such contracts, or other negotiations preliminary to the execution of such contracts;

(iii) The collection of premiums, membership fees, assessments or other consideration for such contracts;

(iv) The transaction of matters subsequent to execution of such contracts and arising out of them; or

(v) Operating under a license or certificate of authority, as an insurer, issued by the Department of Insurance.

(f) "Domiciliary state" means the state in which an insurer is incorporated or organized; or, in the case of an alien insurer, its state of entry.

(g) "Fair consideration" is given for property or obligation:

(i) When in exchange for such property or obligation, as a fair equivalent therefor, and in good faith, property is conveyed or services are rendered or an obligation is incurred or an antecedent debt is satisfied; or

(ii) When such property or obligation is received in good faith to secure a present advance or antecedent debt in amount not disproportionately small as compared to the value of the property or obligation obtained.

(h) "Foreign country" means any other jurisdiction not in any state.

(i) "General assets" means all property, real, personal, or otherwise, not specifically mortgaged, pledged, deposited or otherwise encumbered for the security or benefit of specified persons or classes of persons. As to specifically encumbered property, "general assets" includes all such property or its proceeds in excess of the amount necessary to discharge the sum or sums secured thereby. Assets held in trust and on deposit for the security or benefit of all policyholders or all policyholders and creditors, in more than a single state, shall be treated as general assets.

(j) "Guaranty association" means the Mississippi Insurance Guaranty Association Law, as amended, the Mississippi Life and Health Insurance Guaranty Association Act, as amended, and any other similar entity now or hereafter created by the Legislature of this state for the payment of claims of insolvent insurers. "Foreign guaranty association" means any similar entities now in existence in or hereafter created by the legislature of any other state.

(k) "Insolvency" or "insolvent" means:

(i) For an insurer issuing only assessable fire insurance policies:

(A) The inability to pay any obligation within thirty (30) days after it becomes payable; or

(B) If an assessment be made within thirty (30) days after such date, the inability to pay such obligation thirty (30) days following the date specified in the first assessment notice issued after the date of loss.

(ii) For any other insurer, that the insurer is unable to pay its obligations when they are due, or when its admitted assets do not exceed its liabilities plus the greater of:

(A) Any capital and surplus required by law for its organization; or

(B) The total par or stated value of its authorized and issued capital stock.

(iii) As to any insurer licensed to do business in this state as of March 20, 1991, which does not meet the standard established under subparagraph (ii), the term "insolvency" or "insolvent" shall mean for a period not to exceed three (3) years from March 20, 1991, that it is unable to pay its obligations when they are due or that its admitted assets do not exceed its liabilities plus any required capital contribution ordered by the commissioner under provisions of the insurance law.

(iv) For purposes of this subsection, "liabilities" shall include but not be limited to reserves required by statute or by insurance department general regulations or specific requirements imposed by the commissioner upon a subject company.

(*l*) "Insurer" means any person who has done, purports to do, is doing or is licensed to do an insurance business, and is or has been subject to the authority of, or to liquidation, rehabilitation, reorganization, supervision, or conservation by, any insurance commissioner. For purposes of this chapter, any other persons included under Section 83-24-5 shall be deemed to be insurers.

(m) "Preferred claim" means any claim with respect to which the terms of this chapter accord priority of payment from the general assets of the insurer.

(n) "Receiver" means receiver, liquidator, rehabilitator or conservator as the context requires.

(o) "Reciprocal state" means any state other than this state in which in substance and effect Sections 83-24-35, 83-24-103, 83-24-105, 83-24-109, 83-24-111 and 83-24-113 are in force, and in which provisions are in force requiring that the commissioner or equivalent official be the receiver of a delinquent insurer, and in which some provision exists for the avoidance of fraudulent conveyances and preferential transfers.

(p) "Secured claim" means any claim secured by mortgage, trust deed, pledge, deposit as security, escrow, or otherwise; but not including special deposit claims or claims against general assets. The term also includes claims which have become liens upon specific assets by reason of judicial process.

(q) "Special deposit claim" means any claim secured by a deposit made pursuant to statute for the security or benefit of a limited class or classes of persons, but not including any claim secured by general assets.

(r) "State" means any state, district or territory of the United States and the Panama Canal Zone.

(s) "Transfer" shall include the sale and every other and different mode, direct or indirect, of disposing of or of parting with property or with an interest therein, or with the possession thereof or of fixing a lien upon property or upon an interest therein, absolutely or conditionally, voluntarily, by or without judicial proceedings. The retention of a security title to property delivered to a debtor shall be deemed a transfer suffered by the debtor.

HISTORY: Laws, 1991, ch. 417, § 4, eff from and after passage (approved March 20, 1991).

Cross References — Mississippi Insurance Guaranty Association Law, see §§ 83-23-101 et seq.

Mississippi Life and Health Insurance Guaranty Association Act, see §§ 83-23-201 et seq.

§ 83-24-9. Commencement of delinquency proceedings; jurisdiction.

(1) No delinquency proceeding shall be commenced under this chapter by anyone other than the commissioner and no court shall have jurisdiction to entertain, hear or determine any proceeding commenced by any other person.

(2) No court shall have jurisdiction to entertain, hear or determine any complaint praying for the dissolution, liquidation, rehabilitation, sequestration, conservation or receivership of any insurer; or praying for an injunction or restraining order or other relief preliminary to, incidental to or relating to such proceedings other than in accordance with this chapter.

(3) In addition to other grounds for jurisdiction provided by the law of this state, a court having jurisdiction of the subject matter has jurisdiction over a person served pursuant to the Mississippi Rules of Civil Procedure or other applicable provisions of law in an action brought by the receiver of a domestic insurer or an alien insurer domiciled in this state:

(a) If the person served is an agent, broker, or other person who has at any time written policies of insurance for or has acted in any manner whatsoever on behalf of an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer; or

(b) If the person served is a reinsurer who has at any time entered into a contract of reinsurance with an insurer against which a delinquency proceeding has been instituted, or is an agent or broker of or for the reinsurer, in any action on or incident to the reinsurance contract; or

(c) If the person served is or has been an officer, director, manager, trustee, organizer, promoter, or other person in a position of comparable authority or influence over an insurer against which a delinquency proceeding has been instituted, in any action resulting from or incident to such a relationship with the insurer; or

(d) If the person served is or was at the time of the institution of the delinquency proceeding against the insurer holding assets in which the receiver claims an interest on behalf of the insurer, in any action concerning the assets; or

(e) If the person served is obligated to the insurer in any way whatsoever, in any action on or incident to the obligation.

(4) If the court on motion of any party finds that any action should as a matter of substantial justice be tried in a forum outside this state, the court may enter an appropriate order to stay further proceedings on the action in this state.

(5) All action herein authorized shall be brought in the Chancery Court of the First Judicial District of Hinds County.

HISTORY: Laws, 1991, ch. 417, § 5, eff from and after passage (approved March 20, 1991).

§ 83-24-11. Injunctions and orders; application.

(1) Any receiver appointed in a proceeding under this chapter may at any time apply for, and any court of general jurisdiction may grant, such restraining orders, preliminary and permanent injunctions, and other orders as may be deemed necessary and proper to prevent:

(a) The transaction of further business;

(b) The transfer of property;

(c) Interference with the receiver or with a proceeding under this chapter;

(d) Waste of the insurer's assets;

(e) Dissipation and transfer of bank accounts;

(f) The institution or further prosecution of any actions or proceedings;

(g) The obtaining of preferences, judgments, attachments, garnishments or liens against the insurer, its assets or its policyholders;

(h) The levying of execution against the insurer, its assets or its policyholders;

(i) The making of any sale or deed for nonpayment of taxes or assessments that would lessen the value of the assets of the insurer;

(j) The withholding from the receiver of books, accounts, documents, or other records relating to the business of the insurer; or

(k) Any other threatened or contemplated action that might lessen the value of the insurer's assets or prejudice the rights of policyholders, creditors or shareholders, or the administration of any proceeding under this chapter.

(2) The receiver may apply to any court outside of the state for the relief described in subsection (1).

HISTORY: Laws, 1991, ch. 417, § 6, eff from and after passage (approved March 20, 1991).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 93, 94 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 42 (petition or application for order liquidating and dissolving insolvent insurance company and enjoining transaction of business); Form 44 (order to show cause why insolvent insurance company should not be liquidated and dis-

solved and enjoined from transacting business); Form 45 (order liquidating and dissolving insolvent insurance company and enjoining transaction of business by and actions against insurance company).

CJS.
44 C.J.S., Insurance § 194.

§ 83-24-13. Cooperation with Commissioner of Insurance; penalty for obstructing or interfering with proceedings; hearings.

(1) Any officer, manager, director, trustee, owner, employee or agent of any insurer, or any other persons with authority over or in charge of any segment of the insurer's affairs, shall cooperate with the commissioner in any proceeding under this chapter or any investigation preliminary to the proceeding. The term "person" as used in this section shall include any person who exercises control, directly or indirectly, over activities of the insurer through any holding company or other affiliate of the insurer. "To cooperate" shall include, but shall not be limited to, the following:

(a) To reply promptly in writing to any inquiry from the commissioner requesting such a reply; and

(b) To make available to the commissioner any books, accounts, documents, or other records or information or property of or pertaining to the insurer and in his possession, custody or control.

(2) No person shall obstruct or interfere with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto.

(3) This section shall not be construed to abridge otherwise existing legal rights, including the right to resist a petition for liquidation or other delinquency proceedings, or other orders.

(4) Any person included within subsection (1) who fails to cooperate with the commissioner, or any person who obstructs or interferes with the commissioner in the conduct of any delinquency proceeding or any investigation preliminary or incidental thereto, or who violates any order the commissioner issued validly under this chapter, may:

(a) Be sentenced to pay a fine not exceeding Ten Thousand Dollars ($10,000.00) or to undergo imprisonment for a term of not more than one (1) year, or both; or

(b) After a hearing, be subject to the imposition by the commissioner of a civil penalty not to exceed Ten Thousand Dollars ($10,000.00) and shall be subject further to the revocation or suspension of any insurance licenses issued by the commissioner.

HISTORY: Laws, 1991, ch. 417, § 7, eff from and after passage (approved March 20, 1991).

Cross References — Definitions, generally, see § 83-24-7.
Notice of liquidation as affecting duties of agent of insurer, see § 83-24-45.

RESEARCH REFERENCES

Am. Jur.

1A Am. Jur. Pl & Pr Forms (Rev), Administrative Law, Form 341.2 (complaint, petition, or declaration – by license holder – against administrative agency – to enjoin further proceedings to suspend or revoke license – attempt to suspend or revoke license on grounds not listed in statute authorizing suspension or revocation of license).

§ 83-24-15. Commencement of proceedings under former law; application of current provisions.

Every proceeding commenced under the laws in effect before the enactment of this chapter shall be deemed to have commenced under this chapter for the purpose of conducting the proceeding henceforth, except that in the discretion of the commissioner the proceeding may be continued, in whole or in part, as it would have been continued had this chapter not been enacted.

HISTORY: Laws, 1991, ch. 417, § 8, eff from and after passage (approved March 20, 1991).

Editor's Notes — This chapter was enacted by Chapter 417, Laws of 1991, effective from and after March 20, 1991.

§ 83-24-17. Restrictions on insurer after commencement of delinquency proceedings.

No insurer that is subject to any delinquency proceedings, whether formal or informal (administrative or judicial), shall:

(a) Be released from such proceeding unless such proceeding is converted into a judicial rehabilitation or liquidation proceeding;

(b) Be permitted to solicit or accept new business or request or accept the restoration of any suspended or revoked license or certificate of authority;

(c) Be returned to the control of its shareholders or private management; or

(d) Have any of its assets returned to the control of its shareholders or private management until all payments of or on account of the insurer's contractual obligations by all guaranty associations, along with all expenses thereof and interest on all such payments and expenses, shall have been repaid to the guaranty associations or a plan of repayment by the insurer shall have been approved by the guaranty association.

HISTORY: Laws, 1991, ch. 417, § 9, eff from and after passage (approved March 20, 1991).

§ 83-24-19. Petition for court order for formal delinquency proceeding; content of order; ex parte order; duration of order; affect on contractual obligations; hearings; review of order; notice.

(1) The commissioner may file in the chancery court a petition alleging, with respect to a domestic insurer:

(a) That there exists any grounds that would justify a court order for a formal delinquency proceeding against an insurer under this chapter;

(b) That the interests of policyholders, creditors or the public will be endangered by delay; and

(c) The contents of an order deemed necessary by the commissioner.

(2) Upon a filing under subsection (1), the court may issue forthwith, ex parte and without a hearing, the requested order which shall direct the commissioner to take possession and control of all or a part of the property, books, accounts, documents, and other records of an insurer, and of the premises occupied by it for transaction of its business; and until further order of the court enjoin the insurer and its officers, managers, agents and employees from disposition of its property and from the transaction of its business except with the written consent of the commissioner.

(3) The court shall specify in the order what its duration shall be, which shall be such time as the court deems necessary for the commissioner to ascertain the condition of the insurer. On motion of either party or on its own motion, the court may from time to time hold such hearings as it deems desirable after such notice as it deems appropriate, and may extend, shorten or modify the terms of the seizure order. The court shall vacate the seizure order if the commissioner fails to commence a formal proceeding under this chapter after having had a reasonable opportunity to do so. An order of the court pursuant to a formal proceeding under this chapter shall ipso facto vacate the seizure order.

(4) Entry of a seizure order under this section shall not constitute an anticipatory breach of any contract of the insurer.

(5) An insurer subject to an ex parte order under this section may petition the court at any time after the issuance of such order for a hearing and review of the order. The court shall hold such a hearing and review not more than fifteen (15) days after the request. A hearing under this subsection may be held privately in chambers and it shall be so held if the insurer proceeded against so requests.

(6) If, at any time after the issuance of such an order, it appears to the court that any person whose interest is or will be substantially affected by the order did not appear at the hearing and has not been served, the court may order that notice be given. An order that notice be given shall not stay the effect of any order previously issued by the court.

HISTORY: Laws, 1991, ch. 417, § 10, eff from and after passage (approved March 20, 1991).

Cross References — Delinquency proceeding, defined, see § 83-24-7.
Confidentiality of records, see § 83-24-21.
Discretion of commissioner of insurance to institute proceedings, see § 83-24-107.

§ 83-24-21. Confidentiality of records pertaining to proceedings.

In all proceedings and judicial reviews under Section 83-24-19, all records of the insurer, other documents, and all insurance department files and court records and papers, so far as they pertain to or are a part of the record of the proceedings, shall be and remain confidential except as is necessary to obtain compliance therewith, unless and until the chancery court, after hearing arguments from the parties in chambers, shall order otherwise; or unless the insurer requests that the matter be made public. Until such court order, all papers filed with the clerk of the chancery court shall be held by him in a confidential file.

HISTORY: Laws, 1991, ch. 417, § 11, eff from and after passage (approved March 20, 1991).

Cross References — Discretion of commissioner of insurance to institute proceedings, see § 83-24-107.

§ 83-24-23. Petition for order to rehabilitate domestic insurer or alien insurer domiciled in state; grounds.

The commissioner may apply by petition to the chancery court for an order authorizing him to rehabilitate a domestic insurer or an alien insurer domiciled in this state on any one or more of the following grounds:

(a) The insurer is in such condition that the further transaction of business would be hazardous financially to its policyholders, creditors or the public.

(b) There is reasonable cause to believe that there has been embezzlement from the insurer, wrongful sequestration or diversion of the insurer's assets, forgery or fraud affecting the insurer, or other illegal conduct in, by, or with respect to the insurer that if established would endanger assets in an amount threatening the solvency of the insurer.

(c) The insurer has failed to remove any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, employee, or other person, if the person has been found after notice and hearing by the commissioner to be dishonest or untrustworthy in a way affecting the insurer's business.

(d) Control of the insurer, whether by stock ownership or otherwise, and whether direct or indirect, is in a person or persons found after notice and hearing to be untrustworthy.

(e) Any person who in fact has executive authority in the insurer, whether an officer, manager, general agent, director or trustee, employee, or other person, has refused to be examined under oath by the commissioner concerning its affairs, whether in this state or elsewhere; and after reasonable notice of the fact, the insurer has failed promptly and effectively to terminate the employment and status of the person and all his influence on management.

(f) After demand by the commissioner under Section 83-1-31, Mississippi Code of 1972, or under this chapter, the insurer has failed to promptly make available for examination any of its own property, books, accounts, documents, or other records, or those of any subsidiary or related company within the control of the insurer, or those of any person having executive authority in the insurer so far as they pertain to the insurer.

(g) Without first obtaining the written consent of the commissioner, the insurer has transferred or attempted to transfer, in a manner contrary to Sections 83-6-1 through 83-6-43, or 83-19-71, Mississippi Code of 1972, substantially its entire property or business, or has entered into any transaction the effect of which is to merge, consolidate or reinsure substantially its entire property or business in or with the property or business of any other person.

(h) The insurer or its property has been or is the subject of an application for the appointment of a receiver, trustee, custodian, conservator or sequestrator or similar fiduciary of the insurer or its property otherwise than as authorized under the insurance laws of this state, and such appointment has been made or is imminent, and such appointment might oust the courts of this state of jurisdiction or might prejudice orderly delinquency proceedings under this chapter.

(i) Within the previous four (4) years the insurer has willfully violated its charter or articles of incorporation, its bylaws, any insurance law of this state, or any valid order of the commissioner.

(j) The insurer has failed to pay within sixty (60) days after due date any obligation to any state or any subdivision thereof or any judgment entered in any state, if the court in which such judgment was entered had jurisdiction over such subject matter except that such nonpayment shall not be a ground until sixty (60) days after any good faith effort by the insurer to contest the obligation has been terminated, whether it is before the commissioner or in the courts, or the insurer has systematically attempted to compromise or renegotiate previously agreed settlements with its creditors on the ground that it is financially unable to pay its obligations in full.

(k) The insurer has failed to file its annual report or other financial report required by statute within the time allowed by law and, after written demand by the commissioner, has failed to give an adequate explanation immediately.

(*l*) The board of directors or the holders of a majority of the shares entitled to vote, or a majority of those individuals entitled to the control of those entities request or consent to rehabilitation under this chapter.

HISTORY: Laws, 1991, ch. 417, § 12, eff from and after passage (approved March 20, 1991).

Editor's Notes — Section 83-19-71 referred to in (g) was repealed by Laws of 1991, ch. 501, § 6, eff from and after July 1, 1991. For similar provisions, see §§ 83-19-151 et seq.

Cross References — Restoration of insurer's interest, see § 83-24-31.

Petition for order directing liquidation, see § 83-24-33.

Commissioner of insurance acting as conservator in absence of appointment of domiciliary liquidator, see § 83-24-99.

Application by commissioner for order permitting liquidation of assets, see § 83-24-101.

RESEARCH REFERENCES

ALR.

Duty of liability insurer to initiate settlement negotiations. 51 A.L.R.5th 701.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 93-118 (insolvency, dissolution, and rehabilitation).

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 42 (petition or application for order liquidating and dissolving insolvent insurance company and enjoining transaction of business); Form 44 (order to show cause why insolvent insurance company should not be liquidated and dissolved and enjoined from transacting business); Form 45 (order for liquidating and dissolving insolvent insurance company and enjoining transaction of business by and actions against insurance company).

CJS.

44 C.J.S., Insurance §§ 181-197.

§ 83-24-25. Rehabilitator designated; affect of order of rehabilitation; affect on contractual obligations.

(1) An order to rehabilitate the business of a domestic insurer, or an alien insurer domiciled in this state, shall appoint the commissioner and his successors in office the rehabilitator, and shall direct the rehabilitator forthwith to take possession of the assets of the insurer, and to administer them under the general supervision of the court. The filing or recording of the order with the Clerk of the Chancery Court of the First Judicial District of Hinds County or of the county in which the principal business of the company is conducted, or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale, or other evidence of title duly filed or recorded with that clerk would have imparted. The order to rehabilitate the insurer shall by operation of law vest title to all assets of the insurer in the rehabilitator.

(2) Any order issued under this section shall require accountings to the court by the rehabilitator. Accountings shall be at such intervals as the court specifies in its order, but no less frequently than semiannually. Each accounting shall include a report concerning the rehabilitator's opinion as to the likelihood that a plan will be prepared by the rehabilitator and the timetable for doing so.

(3) Entry of an order of rehabilitation shall not constitute an anticipatory breach of any contracts of the insurer nor shall it be grounds for retroactive revocation or retroactive cancellation of any contracts of the insurer, unless such revocation or cancellation is done by the rehabilitator pursuant to Section 83-24-27.

HISTORY: Laws, 1991, ch. 417, § 13, eff from and after passage (approved March 20, 1991).

Cross References — Claims made under employment contracts by directors, principal officers, or persons performing similar functions, see § 83-24-73.

§ 83-24-27. Appointment of special deputies; powers and duties; compensation; counsel; clerical assistants; advisory committee of policyholders, claimants, or other creditors; cost of administration; implementation of legal proceedings; plans for reorganization, etc.; fraudulent transfers.

(1) The commissioner as rehabilitator may appoint one or more special deputies, who shall have all the powers and responsibilities of the rehabilitator granted under this section, and the commissioner may employ such counsel, clerks and assistants as deemed necessary. The compensation of the special deputy, counsel, clerks and assistants and all expenses of taking possession of the insurer and of conducting the proceedings shall be fixed by the commissioner, with the approval of the court, and shall be paid out of the funds or assets of the insurer. The persons appointed under this section shall serve at the pleasure of the commissioner. The commissioner, as rehabilitator, may, with the approval of the court, appoint an advisory committee of policyholders, claimants, or other creditors including guaranty associations should such a committee be deemed necessary. Such committee shall serve at the pleasure of the commissioner and shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the commissioner or the court in rehabilitation proceedings conducted under this chapter.

(2) In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs so incurred out of any appropriation for the maintenance of the insurance department. Any amounts so advanced for expenses of administration shall be repaid to the commissioner for the use of the insurance department out of the first available money of the insurer.

(3) The rehabilitator may take such action as he deems necessary or appropriate to reform and revitalize the insurer. He shall have all the powers of the directors, officers and managers, whose authority shall be suspended, except as they are redelegated by the rehabilitator. He shall have full power to direct and manage, to hire and discharge employees subject to any contract rights they may have, and to deal with the property and business of the insurer.

(4) If it appears to the rehabilitator that there has been criminal or tortious conduct, or breach of any contractual or fiduciary obligation detrimental to the insurer by any officer, manager, agent, broker, employee or other person, he may pursue all appropriate legal remedies on behalf of the insurer.

(5) If the rehabilitator determines that reorganization, consolidation, conversion, reinsurance, merger or other transformation of the insurer is

appropriate, he shall prepare a plan to effect such changes. Upon application of the rehabilitator for approval of the plan, and after such notice and hearings as the court may prescribe, the court may either approve or disapprove the plan proposed, or may modify it and approve it as modified. Any plan approved under this section shall be, in the judgment of the court, fair and equitable to all parties concerned. If the plan is approved, the rehabilitator shall carry out the plan. In the case of a life insurer, the plan proposed may include the imposition of liens upon the policies of the company, if all rights of shareholders are first relinquished. A plan for a life insurer may also propose imposition of a moratorium upon loan and cash surrender rights under policies, for such period and to such an extent as may be necessary.

(6) The rehabilitator shall have the power under Sections 83-24-51 and 83-24-53 to avoid fraudulent transfers.

HISTORY: Laws, 1991, ch. 417, § 14, eff from and after passage (approved March 20, 1991).

Cross References — Restoration of insurer's interest, see § 83-24-31.

RESEARCH REFERENCES

ALR.

Negligent discharge of employee. 53 A.L.R.5th 219.

§ 83-24-29. Stay of action or proceeding; statute of limitations; defense of laches; standing to appear in proceedings.

(1) Any court in this state before which any action or proceeding is pending in which the insurer is a party or is obligated to defend a party when a rehabilitation order against the insurer is entered, shall stay the action or proceeding for ninety (90) days and such additional time as is necessary for the rehabilitator to obtain proper representation and prepare for further proceedings. The rehabilitator shall take such action respecting the pending litigation as he deems necessary in the interests of justice and for the protection of creditors, policyholders and the public. The rehabilitator shall immediately consider all litigation pending outside this state and shall petition the courts having jurisdiction over that litigation for stays whenever necessary to protect the estate of the insurer.

(2) No statute of limitations or defense of laches shall run with respect to any action by or against an insurer between the filing of a petition for appointment of a rehabilitator for that insurer and the order granting or denying that petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty (60) days after the order of rehabilitation is entered or the petition is denied. The rehabilitator may, upon an order for rehabilitation, within one (1) year or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the insurer upon any cause of action against which the

period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered.

(3) Any guaranty association or foreign guaranty association covering life or health insurance or annuities shall have standing to appear in any court proceeding concerning the rehabilitation of a life or health insurer if such association is or may become liable to act as a result of the rehabilitation.

HISTORY: Laws, 1991, ch. 417, § 15, eff from and after passage (approved March 20, 1991).

§ 83-24-31. Petition for order of liquidation; order of liquidation on grounds of insolvency; petition for order terminating rehabilitation of insurer; restoration of insurer's interest.

(1) Whenever the commissioner believes further attempts to rehabilitate an insurer would substantially increase the risk of loss to creditors, policyholders or the public, or would be futile, the commissioner may petition the court for an order of liquidation. A petition under this subsection shall have the same effect as a petition under Section 83-24-33. The court shall permit the directors of the insurer to take such actions as are reasonably necessary to defend against the petition and may order payment from the estate of the insurer of such costs and other expenses of defense as justice may require.

(2) The protection of the interests of insureds, claimants and the public requires the timely performance of all insurance policy obligations. If the payment of policy obligations is suspended in substantial part for a period of six (6) months at any time after the appointment of the rehabilitator and the rehabilitator has not filed an application for approval of a plan under Section 83-24-27, the rehabilitator shall petition the court for an order of liquidation on grounds of insolvency.

(3) The rehabilitator may at any time petition the court for an order terminating rehabilitation of an insurer. The court shall also permit the directors of the insurer to petition the court for an order terminating rehabilitation of the insurer and may order payment from the estate of the insurer of such costs and other expenses of such petition as justice may require. If the court finds that rehabilitation has been accomplished and that grounds for rehabilitation under Section 83-24-23 no longer exist, it shall order that the insurer be restored to possession of its property and the control of the business. The court may also make that finding and issue that order at any time upon its own motion.

HISTORY: Laws, 1991, ch. 417, § 16, eff from and after passage (approved March 20, 1991).

§ 83-24-33. Petition for order directing liquidation; grounds.

The commissioner may petition the court for an order directing him to liquidate a domestic insurer or an alien insurer domiciled in this state on the basis:

(a) Of any ground for an order of rehabilitation as specified in Section 83-24-23, whether or not there has been a prior order directing the rehabilitation of the insurer;

(b) That the insurer is insolvent; or

(c) That the insurer is in such condition that the further transaction of business would be hazardous, financially or otherwise, to its policyholders, its creditors or the public.

HISTORY: Laws, 1991, ch. 417, § 17, eff from and after passage (approved March 20, 1991).

Cross References — Petition for order of liquidation, see § 83-24-31.
Application by commissioner for order permitting liquidation of assets, see § 83-24-101.

§ 83-24-35. Commissioner, and his successors in office, as liquidator; rights, duties and responsibilities; terms of order to liquidate; financial reports; plan for continuation of insurer's business.

(1) An order to liquidate the business of a domestic insurer shall appoint the commissioner and his successors in office as liquidator, and shall direct the liquidator forthwith to take possession of the assets of the insurer and to administer them under the general supervision of the court. The liquidator shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. The filing or recording of the order with the Clerk of the Chancery Court of the First Judicial District of Hinds County and of the county in which its principal office or place of business is located, or, in the case of real estate, of the county where the property is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that chancery court would have imparted.

(2) Upon issuance of the order, the rights and liabilities of any such insurer and of its creditors, policyholders, shareholders, members and all other persons interested in its estate shall become fixed as of the date of entry of the order of liquidation, except as provided in Sections 83-24-37 and 83-24-73.

(3) An order to liquidate the business of an alien insurer domiciled in this state shall be in the same terms and have the same legal effect as an order to liquidate a domestic insurer, except that the assets and the business in the United States shall be the only assets and business included therein.

(4) At the time of petitioning for an order of liquidation, or at any time thereafter, the commissioner, after making appropriate findings of an insurer's insolvency, may petition the court for a judicial declaration of such insolvency. After providing such notice and hearing as it deems proper, the court may make the declaration.

(5) Any order issued under this section shall require the liquidator to submit financial reports to the court. Financial reports shall include (at a

minimum) the assets and liabilities of the insurer and all funds received or disbursed by the liquidator during the current period. Financial reports shall be filed within one (1) year of the liquidation order and at least annually thereafter.

(6)(a) Within five (5) days of March 20, 1991, or, if later, within five (5) days after the initiation of an appeal of an order of liquidation, which order has not been stayed, the commissioner shall present for the court's approval a plan for the continued performance of the defendant company's policy claims obligations, including the duty to defend insureds under liability insurance policies, during the pendency of an appeal. Such plan shall provide for the continued performance and payment of policy claims obligations in the normal course of events, notwithstanding the grounds alleged in support of the order of liquidation including the ground of insolvency. If the defendant company's financial condition will not, in the judgment of the commissioner, support the full performance of all policy claims obligations during the appeal pendency period, the plan may prefer the claims of certain policyholders and claimants over creditors and interested parties as well as other policyholders and claimants, as the commissioner finds to be fair and equitable considering the relative circumstances of such policyholders and claimants. The court shall examine the plan submitted by the commissioner and if it finds the plan to be in the best interests of the parties, the court shall approve the plan. No action shall lie against the commissioner or any of his deputies, agents, clerks, assistants or attorneys by any party based on preference in an appeal pendency plan approved by the court.

(b) The appeal pendency plan shall not supersede or affect the obligations of any insurance guaranty association.

(c) Any such plans shall provide for equitable adjustments to be made by the liquidator to any distributions of assets to guaranty associations, and in the event that the liquidator pays claims from assets of the estate, which would otherwise be the obligations of any particular guaranty association but for the appeal of the order of liquidation, such that all guaranty associations equally benefit on a pro rata basis from the assets of the estate. Further, if an order of liquidation is set aside upon any appeal, the company shall not be released from delinquency proceedings unless and until all funds advanced by any guaranty association, including reasonable administrative expenses relating to obligations of the company, shall be repaid in full, together with interest at the judgment rate of interest or unless an arrangement for repayment thereof has been made with the consent of all applicable guaranty associations.

HISTORY: Laws, 1991, ch. 417, § 18, eff from and after passage (approved March 20, 1991).

Cross References — Reciprocal state, defined, see § 83-24-7.
Report by liquidator after order of liquidation, see § 83-24-61.
Claims made under employment contracts by directors, principal officers, or persons performing similar functions, see § 83-24-73.

RESEARCH REFERENCES

Practice References.
Business Law Monographs, Volume IN2—Casualty and Liability Insurance (Matthew Bender).

§ 83-24-37. Continuation of insurer's obligations; termination of coverages.

(1) All policies, including bonds and other noncancellable business, other than life or health insurance or annuities, in effect at the time of issuance of an order of liquidation shall continue in force only for the lesser of:

(a) A period of thirty (30) days from the date of entry of the liquidation orders;

(b) The expiration of the policy coverage;

(c) The date when the insured has replaced the insurance coverage with equivalent insurance in another insurer or otherwise terminated the policy;

(d) The liquidator has effected a transfer of the policy obligation pursuant to Section 83-24-41; or

(e) The date proposed by the liquidator and approved by the court to cancel coverage.

(2) An order for liquidation under Section 83-24-39 shall terminate coverages at the time specified in subsection (1) of this section for purposes of any other statute.

(3) Policies of life or health insurance or annuities shall continue in force for such period and under such terms as is provided for by any applicable guaranty association or foreign guaranty association.

(4) Policies of life or health insurance or annuities or any period or coverage of such policies not covered by a guaranty association or foreign guaranty association shall terminate under subsections (1) and (2).

HISTORY: Laws, 1991, ch. 417, § 19, eff from and after passage (approved March 20, 1991).

Cross References — Date of entry of order of liquidation as affecting rights of insurer, etc., see § 83-24-35.

§ 83-24-39. Petition for order to dissolve corporate existence.

The commissioner may petition for an order dissolving the corporate existence of a domestic insurer or the United States branch of an alien insurer domiciled in this state at the time he applies for a liquidation order. The court shall order dissolution of the corporation upon petition by the commissioner upon or after the granting of a liquidation order. If the dissolution has not previously been ordered, it shall be effected by operation of law upon the discharge of the liquidator if the insurer is insolvent but may be ordered by the court upon the discharge of the liquidator if the insurer is under a liquidation order for some other reason.

HISTORY: Laws, 1991, ch. 417, § 20, eff from and after passage (approved March 20, 1991).

Cross References — Continuation or termination of insurer's obligations, see § 83-24-37.

Powers and duties of liquidator, see § 83-24-41.

Maintenance of civil action for damages for benefit of insurer, if order for liquidation or rehabilitation of controlled insurer entered in accordance with this (Insurers Rehabilitation and Liquidation) Act, see § 83-59-11.

§ 83-24-41. Powers and duties of liquidator.

(1) The liquidator shall have the power:

(a) To appoint a special deputy or deputies to act for him under this chapter, and to determine his reasonable compensation. The special deputy shall have all powers of the liquidator granted by this section. The special deputy shall serve at the pleasure of the liquidator.

(b) To employ employees and agents, legal counsel, actuaries, accountants, appraisers, consultants and such other personnel as he may deem necessary to assist in the liquidation.

(c) To appoint, with the approval of the court, an advisory committee of policyholders, claimants or other creditors including guaranty associations should such a committee be deemed necessary. Such committee shall serve without compensation other than reimbursement for reasonable travel and per diem living expenses. No other committee of any nature shall be appointed by the commissioner or the court in liquidation proceedings conducted under this chapter.

(d) To fix the reasonable compensation of employees and agents, legal counsel, actuaries, accountants, appraisers and consultants with the approval of the court.

(e) To pay reasonable compensation to persons appointed and to defray from the funds or assets of the insurer all expenses of taking possession of, conserving, conducting, liquidating, disposing of, or otherwise dealing with the business and property of the insurer. In the event that the property of the insurer does not contain sufficient cash or liquid assets to defray the costs incurred, the commissioner may advance the costs so incurred out of any appropriation for the maintenance of the insurance department. Any amounts so advanced for expenses of administration shall be repaid to the commissioner for the use of the insurance department out of the first available monies of the insurer.

(f) To hold hearings, to subpoena witnesses to compel their attendance, to administer oaths, to examine any person under oath, and to compel any person to subscribe to his testimony after it has been correctly reduced to writing; and in connection therewith to require the production of any books, papers, records or other documents which he deems relevant to the inquiry.

(g) To audit the books and records of all agents of the insurer insofar as those records relate to the business activities of the insurer.

(h) To collect all debts and monies due and claims belonging to the insurer, wherever located, and for this purpose:

(i) To institute timely action in other jurisdictions in order to forestall garnishment and attachment proceedings against such debts;

(ii) To do such other acts as are necessary or expedient to collect, conserve or protect its assets or property, including the power to sell, compound, compromise or assign debts for purposes of collection upon such terms and conditions as he deems best; and

(iii) To pursue any creditor's remedies available to enforce his claims.

(i) To conduct public and private sales of the property of the insurer.

(j) To use assets of the estate of an insurer under a liquidation order to transfer policy obligations to a solvent assuming insurer, if the transfer can be arranged without prejudice to applicable priorities under Section 83-24-83.

(k) To acquire, hypothecate, encumber, lease, improve, sell, transfer, abandon or otherwise dispose of or deal with, any property of the insurer at its market value or upon such terms and conditions as are fair and reasonable. He shall also have power to execute, acknowledge and deliver any and all deeds, assignments, releases and other instruments necessary or proper to effectuate any sale of property or other transaction in connection with the liquidation.

(*l*) To borrow money on the security of the insurer's assets or without security and to execute and deliver all documents necessary to that transaction for the purpose of facilitating the liquidation. Any such funds borrowed may be repaid as an administrative expense and have priority over any other claims in Class 1 under the priority of distribution.

(m) To enter into such contracts as are necessary to carry out the order to liquidate, and to affirm or disavow any contracts to which the insurer is a party.

(n) To continue to prosecute and to institute in the name of the insurer or in his own name any and all suits and other legal proceedings in this state or elsewhere, and to abandon the prosecution of claims he deems unprofitable to pursue further. If the insurer is dissolved under Section 83-24-39, he shall have the power to apply to any court in this state or elsewhere for leave to substitute himself for the insurer as plaintiff.

(o) To prosecute any action which may exist in behalf of the creditors, members, policyholders or shareholders of the insurer against any officer of the insurer, or any other person.

(p) To remove any or all records and property of the insurer to the offices of the commissioner or to such other place as may be convenient for the purposes of efficient and orderly execution of the liquidation. Guaranty associations and foreign guaranty associations shall have such reasonable access to the records of the insurer as is necessary for them to carry out their statutory obligations.

(q) To deposit in one or more banks in this state such sums as are required for meeting current administration expenses and dividend distributions.

(r) To invest all sums not currently needed, unless the court orders otherwise.

(s) To file any necessary documents for record in the office of any chancery clerk or record office in this state or elsewhere where property of the insurer is located.

(t) To assert all defenses available to the insurer as against third persons, including statutes of limitation, statutes of frauds, and the defense of usury. A waiver of any defense by the insurer after a petition in liquidation has been filed shall not bind the liquidator. Whenever a guaranty association or foreign guaranty association has an obligation to defend any suit, the liquidator shall give precedence to such obligation and may defend only in the absence of a defense by such guaranty associations.

(u) To exercise and enforce all the rights, remedies and powers of any creditor, shareholder, policyholder or member, including any power to avoid any transfer or lien that may be given by the general law and that is not included with Sections 83-24-51 through 83-24-55.

(v) To intervene in any proceeding wherever instituted that might lead to the appointment of a receiver or trustee, and to act as the receiver or trustee whenever the appointment is offered.

(w) To enter into agreements with any receiver or commissioner of any other state relating to the rehabilitation, liquidation, conservation or dissolution of an insurer doing business in both states.

(x) To exercise all powers now held or hereafter conferred upon receivers by the laws of this state not inconsistent with the provisions of this chapter.

(2)(a) If a company placed in liquidation issued liability policies on a claims-made basis, which provided an option to purchase an extended period to report claims, then the liquidator may make available to holders of such policies, for a charge, an extended period to report claims as stated herein. The extended reporting period shall be made available only to those insureds who have not secured substitute coverage. The extended period made available by the liquidator shall begin upon termination of any extended period to report claims in the basic policy and shall end at the earlier of the final date for filing of claims in the liquidation proceeding or eighteen (18) months from the order of liquidation.

(b) The extended period to report claims made available by the liquidator shall be subject to the terms of the policy to which it relates. The liquidator shall make available such extended period within sixty (60) days after the order of liquidation at a charge to be determined by the liquidator subject to approval of the court. Such offer shall be deemed rejected unless the offer is accepted in writing and the charge is paid within ninety (90) days after the order of liquidation. No commissions, premium taxes, assessments or other fees shall be due on the charge pertaining to the extended period to report claims.

(3) The enumeration, in this section, of the powers and authority of the liquidator shall not be construed as a limitation upon him, nor shall it exclude in any manner his right to do such other acts not herein specifically enumerated or otherwise provided for, as may be necessary or appropriate for the accomplishment of or in aid of the purpose of liquidation.

(4) Notwithstanding the powers of the liquidator as stated in subsections (1) and (2) above, the liquidator shall have no obligation to defend claims or to continue to defend claims subsequent to the entry of a liquidation order.

HISTORY: Laws, 1991, ch. 417, § 21, eff from and after passage (approved March 20, 1991).

Cross References — Continuation or termination of insurer's obligations, see § 83-24-37.

Priority of distribution of claims, see § 83-24-83.

§ 83-24-43. Notice of liquidation order; filing claims with liquidator.

(1) Unless the court otherwise directs, the liquidator shall give or cause to be given notice of the liquidation order as soon as possible:

(a) By first class mail and either by telegram or telephone to the insurance commissioner of each jurisdiction in which the insurer is doing business;

(b) By first class mail to any guaranty association or foreign guaranty association which is or may become obligated as a result of the liquidation;

(c) By first class mail to all insurance agents of the insurer;

(d) By first class mail to all persons known or reasonably expected to have claims against the insurer, including all policyholders, at their last known address as indicated by the records of the insurer; and

(e) By publication in a newspaper of general circulation in the county in which the insurer has its principal place of business and in such other locations as the liquidator deems appropriate.

(2) Except as otherwise established by the liquidator with approval of the court, notice to potential claimants under subsection (1) shall require claimants to file with the liquidator their claims, together with proper proofs thereof under Section 83-24-71, on or before a date the liquidator shall specify in the notice. The liquidator need not require persons claiming cash surrender values or other investment values in life insurance and annuities to file a claim. All claimants shall have a duty to keep the liquidator informed of any changes of address.

(3)(a) Notice under subsection (1) to agents of the insurer and to potential claimants who are policyholders shall include, where applicable, notice that coverage by state guaranty associations may be available for all or part of policy benefits in accordance with applicable state guaranty laws.

(b) The liquidator shall promptly provide to the guaranty associations such information concerning the identities and addresses of such policyholders and their policy coverages as may be within the liquidator's possession or control, and otherwise cooperate with guaranty associations to assist them in providing to such policyholders timely notice of the guaranty associations' coverage of policy benefits, including, as applicable, coverage of claims and continuation or termination of coverages.

(4) If notice is given in accordance with this section, the distribution of assets of the insurer under this chapter shall be conclusive with respect to all claimants, whether or not they received notice.

HISTORY: Laws, 1991, ch. 417, § 22, eff from and after passage (approved March 20, 1991).

Cross References — Filing proof of claims, see § 83-24-69.
Claim filed by insurer, see § 83-24-75.
Priority of distribution of claims, see § 83-24-83.

§ 83-24-45. Agent of insurer; duties following notice of liquidation; penalties.

(1) Every person who receives notice in the form prescribed in Section 83-24-43 that an insurer which he represents as an agent is the subject of a liquidation order shall, within thirty (30) days of such notice provide to the liquidator (in addition to the information he may be required to provide pursuant to Section 83-24-13) the information in the agent's records related to any policy issued by the insurer through the agent, and, if the agent is a general agent, the information in the general agent's records related to any policy issued by the insurer through an agent under contract to him, including the name and address of such subagent. A policy shall be deemed issued through an agent if the agent has a property interest in the expiration of the policy, or if the agent has had in his possession a copy of the declarations of the policy at any time during the life of the policy, except where the ownership of the expiration of the policy has been transferred to another.

(2) Any agent failing to provide information to the liquidator as required in subsection (1) may be subject to payment of a penalty of not more than One Thousand Dollars ($1,000.00) and may have his licenses suspended after a hearing held by the commissioner.

HISTORY: Laws, 1991, ch. 417, § 23, eff from and after passage (approved March 20, 1991).

§ 83-24-47. Action or proceeding against insurer after order appointing liquidator prohibited; injunctions; action on behalf of insurer; limitation of actions; rights of guaranty association.

(1) Upon issuance of an order appointing a liquidator of a domestic insurer or of an alien insurer domiciled in this state, no action at law or equity or in arbitration shall be brought against the insurer or liquidator, whether in this state or elsewhere, nor shall any such existing actions be maintained or further presented after issuance of such order. The courts of this state shall give full faith and credit to injunctions against the liquidator or the company or the continuation of existing actions against the liquidator or the company, when such injunctions are included in an order to liquidate an insurer issued

pursuant to corresponding provisions in other states. Whenever, in the liquidator's judgment, protection of the estate of the insurer necessitates intervention in an action against the insurer that is pending outside this state, he may intervene in the action. The liquidator may defend any action in which he intervenes under this section at the expense of the estate of the insurer.

(2) The liquidator may, upon or after an order for liquidation, within two (2) years or such other longer time as applicable law may permit, institute an action or proceeding on behalf of the estate of the insurer upon any cause of action against which the period of limitation fixed by applicable law has not expired at the time of the filing of the petition upon which such order is entered. Where, by any agreement, a period of limitation is fixed for instituting a suit or proceeding upon any claim, or for filing any claim, proof of claim, proof of loss, demand, notice, or the like, or where in any proceeding, judicial or otherwise, a period of limitation is fixed, either in the proceeding or by applicable law, for taking any action, filing any claim or pleading, or doing any act, and where in any such case the period had not expired at the date of the filing of the petition; the liquidator may, for the benefit of the estate, take any such action or do any such act required of or permitted to the insurer, within a period of one hundred eighty (180) days subsequent to the entry of an order for liquidation, or within such further period as is shown to the satisfaction of the court not to be unfairly prejudicial to the other party.

(3) No statute of limitation or defense of laches shall run with respect to any action against an insurer between the filing of a petition for liquidation against an insurer and the denial of the petition. Any action against the insurer that might have been commenced when the petition was filed may be commenced for at least sixty (60) days after the petition is denied.

(4) Any guaranty association or foreign guaranty association shall have standing to appear in any court proceeding concerning the liquidation of an insurer if such association is or may become liable to act as a result of the liquidation.

HISTORY: Laws, 1991, ch. 417, § 24, eff from and after passage (approved March 20, 1991).

§ 83-24-49. Preparation of list of insurer's assets.

(1) As soon as practicable after the liquidation order but not later than one hundred twenty (120) days thereafter, the liquidator shall prepare in duplicate a list of the insurer's assets. The list shall be amended or supplemented from time to time as the liquidator may determine. One (1) copy shall be filed in the office of the clerk of the chancery court and one (1) copy shall be retained for the liquidator's files. All amendments and supplements shall be similarly filed.

(2) The liquidator shall reduce the assets to a degree of liquidity that is consistent with the effective execution of the liquidation.

(3) A submission to the court for disbursement of assets in accordance with Section 83-24-67 fulfills the requirements of subsection (1) of this section.

HISTORY: Laws, 1991, ch. 417, § 25, eff from and after passage (approved March 20, 1991).

§ 83-24-51. Transfers by insurer prior to petition for rehabilitation or liquidation; voiding transfers.

(1) Every transfer made or suffered and every obligation incurred by an insurer within one (1) year prior to the filing of a successful petition for rehabilitation or liquidation under this chapter is fraudulent as to then existing and future creditors if made or incurred without fair consideration, or with actual intent to hinder, delay or defraud either existing or future creditors. A transfer made or an obligation incurred by an insurer ordered to be rehabilitated or liquidated under this chapter, which is fraudulent under this section, may be voided by the receiver, except as to a person who in good faith is a purchaser, lienor or obligee for a present fair equivalent value, and except that any purchaser, lienor or obligee, who in good faith has given a consideration less than fair for such transfer, lien or obligation, may retain the property, lien or obligation as security for repayment. The court may, on due notice, order any such transfer or obligation to be preserved for the benefit of the estate, and in that event the receiver shall succeed to and may enforce the rights of the purchaser, lienor or obligee.

(2)(a) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee under Section 83-24-55.

(b) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(c) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(d) Any transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(e) The provisions of this subsection apply whether or not there are or were creditors who might have obtained any liens or persons who might have become bona fide purchasers.

(3) Any transaction of the insurer with a reinsurer shall be deemed fraudulent and may be voided by the receiver under subsection (1) if:

(a) The transaction consists of the termination, adjustment or settlement of a reinsurance contract in which the reinsurer is released from any part of its duty to pay the originally specified share of losses that had occurred prior to the time of the transactions, unless the reinsurer gives a present fair equivalent value for the release; and

(b) Any part of the transaction took place within one (1) year prior to the date of filing of the petition through which the receivership was commenced.

(4) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (1) shall be personally liable therefor and shall be bound to account to the liquidator.

HISTORY: Laws, 1991, ch. 417, § 26, eff from and after passage (approved March 20, 1991).

Cross References — Fraudulent transfers, voiding, see § 83-24-27.

Powers and duties of liquidator, see § 83-24-41.

Transfer of real property of insurer after petition for rehabilitation or liquidation, see § 83-24-53.

Preference transfer, see § 83-24-55.

Filing proof of claims, see § 83-24-69.

§ 83-24-53. Transfer of real property of insurer after petition for rehabilitation or liquidation.

(1) After a petition for rehabilitation or liquidation has been filed, a transfer of any of the real property of the insurer made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value; or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred. The commencement of a proceeding in rehabilitation or liquidation shall be constructive notice upon the recording of a copy of the petition for or order of rehabilitation or liquidation with the chancery court in the county where any real property in question is located. The exercise by a court of the United States or any state or jurisdiction to authorize or effect a judicial sale of real property of the insurer within any county in any state shall not be impaired by the pendency of such a proceeding unless the copy is recorded in the county prior to the consummation of the judicial sale.

(2) After a petition for rehabilitation or liquidation has been filed and before either the receiver takes possession of the property of the insurer or an order of rehabilitation or liquidation is granted:

(a) A transfer of any of the property of the insurer, other than real property, made to a person acting in good faith shall be valid against the receiver if made for a present fair equivalent value; or, if not made for a present fair equivalent value, then to the extent of the present consideration actually paid therefor, for which amount the transferee shall have a lien on the property so transferred.

(b) A person indebted to the insurer or holding property of the insurer may, if acting in good faith, pay the indebtedness or deliver the property, or any part thereof, to the insurer or upon his order, with the same effect as if the petition were not pending.

(c) A person having actual knowledge of the pending rehabilitation or liquidation shall be deemed not to act in good faith.

(d) A person asserting the validity of a transfer under this section shall have the burden of proof. Except as elsewhere provided in this section, no transfer by or on behalf of the insurer after the date of the petition for liquidation by any person other than the liquidator shall be valid against the liquidator.

(3) Every person receiving any property from the insurer or any benefit thereof which is a fraudulent transfer under subsection (1) shall be personally liable therefor and shall be bound to account to the liquidator.

(4) Nothing in this chapter shall impair the negotiability of currency or negotiable instruments.

HISTORY: Laws, 1991, ch. 417, § 27, eff from and after passage (approved March 20, 1991).

Cross References — Fraudulent transfers, voiding, see § 83-24-27.
Powers and duties of liquidator, see § 83-24-41.
Transfers by insurer prior to petition for rehabilitation or liquidation, see § 83-24-51.

§ 83-24-55. Preference transfer; voiding.

(1)(a) A preference is a transfer of any of the property of an insurer to or for the benefit of a creditor, for or on account of an antecedent debt, made or suffered by the insurer within one (1) year before the filing of a successful petition for liquidation under this chapter, the effect of which transfer may be to enable the creditor to obtain a greater percentage of this debt than another creditor of the same class would receive. If a liquidation order is entered while the insurer is already subject to a rehabilitation order, then such transfers shall be deemed preferences if made or suffered within one (1) year before the filing of the successful petition for rehabilitation, or within two (2) years before the filing of the successful petition for liquidation, whichever time is shorter.

(b) Any preference may be voided by the liquidator if:

(i) The insurer was insolvent at the time of the transfer; or

(ii) The transfer was made within four (4) months before the filing of the petition; or

(iii) The creditor receiving it or to be benefited thereby or his agent acting with reference thereto had, at the time when the transfer was made, reasonable cause to believe that the insurer was insolvent or was about to become insolvent; or

(iv) The creditor receiving it was an officer, or any employee or attorney or other person who was in fact in a position of comparable influence in the insurer to an officer whether or not he held such position, or any shareholder holding, directly or indirectly, more than five percent (5%) of any class of any equity security issued by the insurer, or any other person, firm, corporation, association, or aggregation of persons with whom the insurer did not deal at arm's length.

(c) When the preference is voidable, the liquidator may recover the property or, if it has been converted, its value from any person who has received or converted the property; except where a bona fide purchaser or lienor has given less than fair equivalent value, he shall have a lien upon the property to the extent of the consideration actually given by him. If a preference by way of lien or security title is voidable, the court may on due notice order the lien or title to be preserved for the benefit of the estate and the lien or title shall pass to the liquidator.

(2)(a) A transfer of property other than real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent lien obtainable by legal or equitable proceedings on a simple contract could become superior to the rights of the transferee.

(b) A transfer of real property shall be deemed to be made or suffered when it becomes so far perfected that no subsequent bona fide purchaser from the insurer could obtain rights superior to the rights of the transferee.

(c) A transfer which creates an equitable lien shall not be deemed to be perfected if there are available means by which a legal lien could be created.

(d) A transfer not perfected prior to the filing of a petition for liquidation shall be deemed to be made immediately before the filing of the successful petition.

(e) The provisions of this subsection apply whether or not there are or were creditors who might have obtained liens or persons who might have become bona fide purchasers.

(3)(a) A lien obtainable by legal or equitable proceedings upon a simple contract is one arising in the ordinary course of such proceedings upon the entry or docketing of a judgment or decree, or upon attachment, garnishment, execution, or like process, whether before, upon, or after judgment or decree and whether before or upon levy. It does not include liens which under applicable law are given a special priority over other liens which are prior in time.

(b) A lien obtainable by legal or equitable proceedings could become superior to the rights of a transferee, or a purchaser could obtain rights superior to the rights of a transferee within the meaning of subsection (2), if such consequences would follow only from the lien or purchase itself, or from the lien or purchase followed by any step wholly within the control of the respective lienholder or purchaser, with or without the aid of ministerial action by public officials. Such a lien could not, however, become superior and such a purchase could not create superior rights for the purpose of subsection (2) through any acts subsequent to the obtaining of such a lien or subsequent to such a purchase which require the agreement or concurrence of any third party or which require any further judicial action or ruling.

(4) A transfer of property for or on account of a new and contemporaneous consideration which is deemed under subsection (2) to be made or suffered after the transfer because of delay in perfecting it does not thereby become a transfer for or on account of an antecedent debt if any acts required by the applicable law to be performed in order to perfect the transfer as against liens or bona fide purchasers' rights are performed within twenty-one (21) days or any period expressly allowed by the law, whichever is less. A transfer to secure a future loan, if such a loan is actually made, or a transfer which becomes security for a future loan, shall have the same effect as a transfer for or on account of a new and contemporaneous consideration.

(5) If any lien deemed voidable under subsection (1)(b) has been dissolved by the furnishing of a bond or other obligation, the surety on which has been indemnified directly or indirectly by the transfer of or the creation of a lien

upon any property of an insurer before the filing of a petition under this chapter which results in a liquidation order, the indemnifying transfer or lien shall also be deemed voidable.

(6) The property affected by any lien deemed voidable under subsections (1) and (5) shall be discharged from such lien, and that property and any of the indemnifying property transferred to or for the benefit of a surety shall pass to the liquidator, except that the court may on due notice order any such lien to be preserved for the benefit of the estate and the court may direct that such conveyance be executed as may be proper or adequate to evidence the title of the liquidator.

(7) The court shall have summary jurisdiction of any proceeding by the liquidator to hear and determine the rights of any parties under this section. Reasonable notice of any hearing in the proceeding shall be given to all parties in interest, including the obligee of a releasing bond or other like obligation. When an order is entered for the recovery of indemnifying property in kind or for the avoidance of an indemnifying lien, the court, upon application of any party in interest, shall in the same proceeding ascertain the value of the property or lien, and if the value is less than the amount for which the property is indemnity or than the amount of the lien, the transferee or lienholder may elect to retain the property or lien upon payment of its value, as ascertained by the court, to the liquidator, within such reasonable times as the court shall fix.

(8) The liability of the surety under a releasing bond or other like obligation shall be discharged to the extent of the value of the indemnifying property recovered or the indemnifying lien nullified and voided by the liquidator, or where the property is retained under subsection (7) to the extent of the amount paid to the liquidator.

(9) If a creditor has been preferred, and afterward in good faith gives the insurer further credit without security of any kind, for property which becomes a part of the insurer's estate, the amount of the new credit remaining unpaid at the time of the petition may be set off against the preference which would otherwise be recoverable from him.

(10) If an insurer shall, directly or indirectly, within four (4) months before the filing of a successful petition for liquidation under this chapter, or at any time in contemplation of a proceeding to liquidate it, pay money or transfer property to an attorney-at-law for services rendered or to be rendered, the transactions may be examined by the court on its own motion or shall be examined by the court on petition of the liquidator and shall be held valid only to the extent of a reasonable amount to be determined by the court, and the excess may be recovered by the liquidator for the benefits of the estate. If the attorney is in a position of influence with the insurer or an affiliate thereof, payment of any money or the transfer of any property to the attorney-at-law for services rendered or to be rendered shall be governed by the provision of subsection (1)(b)(iv).

(11)(a) Every officer, manager, employee, shareholder, member, subscriber, attorney or any other person acting on behalf of the insurer who knowingly participates in giving any preference when he has reasonable cause to believe the insurer is or is about to become insolvent at the time of the preference shall be personally liable to the liquidator for the amount of the preference. It is permissible to infer that there is a reasonable cause to so believe if the transfer was made within four (4) months before the date of filing of this successful petition for liquidation.

(b) Every person receiving any property from the insurer or the benefit thereof as a preference voidable under subsection (1) shall be personally liable therefor and shall be bound to account to the liquidator.

(c) Nothing in this subsection shall prejudice any other claim by the liquidator against any person.

HISTORY: Laws, 1991, ch. 417, § 28, eff from and after passage (approved March 20, 1991).

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in paragraph (a) of subsection (1). The word "credit" was changed to "creditor." The Joint Committee ratified the correction at its December 3, 1996, meeting.

Cross References — Powers and duties of liquidator, see § 83-24-41.

Transfer of property by insurer prior to petition for rehabilitation or liquidation, see § 83-24-51.

Filing proof of claims, see § 83-24-69.

§ 83-24-57. Surrender of preference, lien, conveyance, transfer, assignment or encumbrance by creditor.

(1) No claims of a creditor who has received or acquired a preference, lien, conveyance, transfer, assignment or encumbrance voidable under this chapter shall be allowed unless he surrenders the preference, lien, conveyance, transfer, assignment or encumbrance. If the avoidance is effected by a proceeding in which a final judgment has been entered, the claim shall not be allowed unless the money is paid or the property is delivered to the liquidator within thirty (30) days from the date of the entering of the final judgment, except that the court having jurisdiction over the liquidation may allow further time if there is an appeal or other continuation of the proceeding.

(2) A claim allowable under subsection (1) by reason of the avoidance, whether voluntary or involuntary, or a preference, lien, conveyance, transfer, assignment or encumbrance, may be filed as an excused last filing under Section 83-24-69 if filed within thirty (30) days from the date of the avoidance, or within the further time allowed by the court under subsection (1).

HISTORY: Laws, 1991, ch. 417, § 29, eff from and after passage (approved March 20, 1991).

Cross References — Filing proof of claims, see § 83-24-69.

§ 83-24-59. Mutual debts or mutual credits between insurer and another person; setoff.

(1) Mutual debts or mutual credits, whether arising out of one or more

contracts between the insurer and another person in connection with any action or proceeding under this chapter, shall be set off and the balance only shall be allowed or paid, except as provided in Section 83-24-65.

(2) No set off shall be allowed in favor of any person where:

(a) The obligation of the insurer to the person would not at the date of the filing of a petition for liquidation entitle the person to share as a claimant in the assets of the insurer; or

(b) The obligation of the insurer to the person was purchased by or transferred to the person with a view to its being used as a set off;

(c) The obligation of the person is to pay an assessment levied against the members or subscribers of the insurer, or is to pay a balance upon a subscription to the capital stock of the insurer, or is in any other way in the nature of a capital contribution.

HISTORY: Laws, 1991, ch. 417, § 30; Laws, 1997, ch. 351, § 1, eff from and after July 1, 1997.

§ 83-24-61. Report by liquidator after order of liquidation; assessments; notice.

(1) As soon as practicable but not more than two (2) years from the date of an order of liquidation under Section 83-24-35 of an insurer issuing assessable policies, the liquidator shall make a report to the court setting forth:

(a) The reasonable value of the assets of the insurer;

(b) The insurer's probable total liabilities;

(c) The probable aggregate amount of the assessment necessary to pay all claims of creditors and expenses in full, including expenses of administration and costs of collecting the assessment; and

(d) A recommendation as to whether or not an assessment should be made and in what amount.

(2)(a) Upon the basis of the report provided in subsection (1), including any supplements and amendments thereto, the court may levy one or more assessments against all members of the insurer who are subject to assessment.

(b) Subject to any applicable legal limits on assessability, the aggregate assessment shall be for the amount that the sum of the probable liabilities, the expenses of administration, and the estimated cost of collection of the assessment, exceeds the value of existing assets, with due regard being given to assessments that cannot be collected economically.

(3) After levy of assessment under subsection (2), the liquidator shall issue an order directing each member who has not paid the assessment pursuant to the order to show cause why the liquidator should not pursue a judgment therefor.

(4) The liquidator shall give notice of the order to show cause by publication, and by first class mail to each member liable thereunder mailed to his last known address as it appears on the insurer's records, at least twenty (20) days before the return day of the order, to show cause.

(5)(a) If a member does not appear and serve duly verified objections upon the liquidator on or before the return day of the order to show cause under subsection (3), the court shall make an order adjudging the member liable for the amount of the assessment against him pursuant to subsection (3), together with costs, and the liquidator shall have a judgment against the member therefor.

(b) If on or before such return day, the member appears and serves duly verified objections upon the liquidator, the commissioner may hear and determine the matter or may appoint a referee to hear it and make such order as the facts warrant. In the event that the commissioner determines that such objections do not warrant relief from assessment, the member may request the court to review the matter and vacate the order to show cause.

(6) The liquidator may enforce any order or collect any judgment under subsection (5) by any lawful means.

HISTORY: Laws, 1991, ch. 417, § 31, eff from and after passage (approved March 20, 1991).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 93, 94 et seq.

CJS.
44 C.J.S., Insurance § 193.

§ 83-24-63. Recovery from reinsurers; amount.

The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of the delinquency proceedings, regardless of any provision in the reinsurance contract or other agreement. Payment made directly to an insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate except when the reinsurance contract provided for direct coverage of a named insured and the payment was made in discharge of that obligation.

HISTORY: Laws, 1991, ch. 417, § 32, eff from and after passage (approved March 20, 1991).

§ 83-24-65. Payment of premiums; recovery of unearned premiums; credits; setoffs; violation of provisions; penalties; notice of violation; hearing; appeal.

(1)(a) An agent, broker, premium finance company, or any other person, other than the insured, responsible for the payment of a premium shall be obligated to pay any unpaid premium for the full policy term due the insurer at the time of the declaration of insolvency, whether earned or unearned, as shown on the records of the insurer. The liquidator shall also have the right to recover from such person any part of an unearned premium that represents commission of such person. Credits or setoffs or both shall not be allowed to an agent, broker, or premium finance company for any amounts advanced to the insurer by the agent, broker, or premium finance company on behalf of, but in the absence of a payment by, the insured.

(b) An insured shall be obligated to pay any unpaid earned premium due the insurer at the time of the declaration of insolvency, as shown on the records of the insurer.

(2) Upon satisfactory evidence of a violation of this section, the commissioner may pursue either one or both of the following courses of action:

(a) Suspend or revoke or refuse to renew the licenses of such offending party or parties.

(b) Impose a penalty of not more than One Thousand Dollars ($1,000.00) for each and every act in violation of this section by the party or parties.

(3) Before the commissioner shall take any action as set forth in subsection (2), he shall give written notice to the person, company, association or exchange accused of violating the law, stating specifically the nature of the alleged violation; and fixing a time and place, at least ten (10) days thereafter, when a hearing on the matter shall be held. After such hearing, or upon failure of the accused to appear at such hearing, the commissioner, if he shall find such violation, shall impose such of the penalties under subsection (2) as he deems advisable.

(4) When the commissioner shall take action in any or all of the ways set out in subsection (2), the party aggrieved may appeal the action to the court.

HISTORY: Laws, 1991, ch. 417, § 33, eff from and after passage (approved March 20, 1991).

Cross References — Setoff of mutual debts or mutual credits between insurer and another person, see § 83-24-59.

§ 83-24-67. Disbursement of assets after final determination of insolvency.

(1) Within one hundred twenty (120) days of a final determination of insolvency of an insurer by a court of competent jurisdiction of this state, the liquidator shall apply to the court for approval of a proposal to disburse assets out of marshalled assets, from time to time as such assets become available, to a guaranty association or foreign guaranty association having obligations because of such insolvency. If the liquidator determines that there are insufficient assets to disburse, the application required by this section shall be considered satisfied by a filing by the liquidator stating the reasons for this determination.

(2) Such proposal shall at least include provisions for:

(a) Reserving amounts for the payment of expenses of administration and the payment of claims of secured creditors, to the extent of the value of the security held, and claims falling within the priorities established in Classes 1 and 2 in Section 83-24-83;

(b) Disbursement of the assets marshalled to date and subsequent disbursement of assets as they become available;

(c) Equitable allocation of disbursements to each of the guaranty associations and foreign guaranty associations entitled thereto;

(d) The securing by the liquidator from each of the associations entitled to disbursements pursuant to this section of an agreement to return to the liquidator such assets, together with income earned on assets previously disbursed, as may be required to pay claims of secured creditors and claims falling within the priorities established in Section 83-24-83 in accordance with such priorities. No bond shall be required of any such association; and

(e) A full report to be made by each association to the liquidator accounting for all assets so disbursed to the association, all disbursements made therefrom, any interest earned by the association on such assets, and any other matter as the court may direct.

(3) The liquidator's proposal shall provide for disbursements to the associations in amounts estimated at least equal to the claim payments made or to be made thereby for which such associations could assert a claim against the liquidator, and shall further provide that if the assets available for disbursement from time to time do not equal or exceed the amount of such claim payments made or to be made by the association, then disbursements shall be in the amount of available assets.

(4) The liquidator's proposal shall, with respect to an insolvent insurer writing life or health insurance or annuities, provide for disbursements of assets to any guaranty association or any foreign guaranty association covering life or health insurance or annuities or to any other entity or organization reinsuring, assuming or guaranteeing policies or contracts of insurance under the acts creating such associations.

(5) Notice of such application shall be given to the association in and to the commissioners of insurance of each of the states. Any such notice shall be deemed to have been given when deposited in the United States certified mails, first class postage prepaid, at least thirty (30) days prior to submission of such application to the court. Action on the application may be taken by the court, provided the above required notice has been given and provided further that the liquidator's proposal complies with subsection (2)(a) and (b).

HISTORY: Laws, 1991, ch. 417, § 34, eff from and after passage (approved March 20, 1991).

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "subsection (2)(a) and (b)" for "subsections (2)(a) and (b)" at the end of (5). The Joint Committee ratified the correction at its August 10, 2022, meeting.

Cross References — Preparation of list of insurer's assets, see § 83-24-49.
Priority of distribution of claims, see § 83-24-83.

§ 83-24-69. Filing proof of claims; late filing.

(1) Proof of all claims shall be filed with the liquidator in the form required by Section 83-24-71 on or before the last day for filing specified in the

notice required under Section 83-24-43, except that proof of claims for cash surrender values or other investment values in life insurance and annuities need not be filed unless the liquidator expressly so requires.

(2) The liquidator may permit a claimant making a late filing to share in distributions, whether past or future, as if he were not late, to the extent that any such payment will not prejudice the orderly administration of the liquidation, under the following circumstances:

(a) The existence of the claim was not known to the claimant and that he filed his claim as promptly thereafter as reasonably possible after learning of it;

(b) A transfer to a creditor was avoided under Sections 83-24-51 through 83-24-55, or was voluntarily surrendered under Section 83-24-57, and that the filing satisfies the conditions of Section 83-24-57;

(c) The valuation under Section 83-24-81, of security held by a secured creditor shows a deficiency, which is filed within thirty (30) days after the valuation.

(3) The liquidator shall permit late filing claims to share in distributions, whether past or future, as if they were not late, if such claims are claims of a guaranty association or foreign guaranty association for reimbursement of covered claims paid or expenses incurred, or both, subsequent to the last day for filing where such payments were made and expenses incurred as provided by law.

(4) The liquidator may consider any claim filed late which is not covered by subsection (2), and permit it to receive distributions which are subsequently declared on any claims of the same or lower priority if the payment does not prejudice the orderly administration of the liquidation. The late-filing claimant shall receive, at each distribution, the same percentage of the amount allowed on his claim as is then being paid to claimants of any lower priority. This shall continue until his claim has been paid in full.

HISTORY: Laws, 1991, ch. 417, § 35, eff from and after passage (approved March 20, 1991).

Cross References — Surrender of preference, lien, conveyance, transfer, assignment or encumbrance by creditor, see § 83-24-57.

Content of proof of claims, see § 83-24-71.

Contingent claims, see § 83-24-73.

Claims by residents of Mississippi in liquidation proceeding in reciprocal state against insurer domiciled in that state, see § 83-24-111.

§ 83-24-71. Content of proof of claims.

(1) Proof of claim shall consist of a statement signed by the claimant that includes all of the following that are applicable:

(a) The particulars of the claim including the consideration given for it;

(b) The identity and amount of the security on the claim;

(c) The payments made on the debt, if any;

(d) That the sum claimed is justly owing and that there is no setoff, counterclaim or defense to the claim;

(e) Any right of priority of payment or other specific right asserted by the claimants;

(f) A copy of the written instrument which is the foundation of the claim; and

(g) The name and address of the claimant and the attorney who represents him, if any.

(2) No claim need be considered or allowed if it does not contain all the information in subsection (1) which may be applicable. The liquidator may require that a prescribed form be used, and may require that other information and documents be included.

(3) At any time the liquidator may request the claimant to present information or evidence supplementary to that required under subsection (1) and may take testimony under oath, require production of affidavits or depositions, or otherwise obtain additional information or evidence.

(4) No judgment or order against an insured or the insurer entered after the date of filing of a successful petition for liquidation, and no judgment or order against an insured or the insurer entered at any time by default or by collusion, need be considered as evidence of liability or of quantum of damages. No judgment or order against an insured or the insurer entered within four (4) months before the filing of the petition need be considered as evidence of liability or of the quantum of damages.

(5) All claims of a guaranty association or foreign guaranty association shall be in such form and contain such substantiation as may be agreed to by the association and the liquidator.

HISTORY: Laws, 1991, ch. 417, § 36, eff from and after passage (approved March 20, 1991).

Cross References — Notice of liquidation order, see § 83-24-43.
Filing proof of claims, see § 83-24-69.
Claims by residents of Mississippi in liquidation proceeding in reciprocal state against insurer domiciled in that state, see § 83-24-111.

§ 83-24-73. Claim of third party which is contingent on obtaining judgment against insurer; claims due except for passage of time; employment contracts.

(1) The claim of a third party which is contingent only on his first obtaining a judgment against the insured shall be considered and allowed as if there were no such contingency.

(2) A claim may be allowed even if contingent, if it is filed in accordance with Section 83-24-69. It may be allowed and may participate in all distributions declared after it is filed to the extent that it does not prejudice the orderly administration of the liquidation.

(3) Claims that are due except for the passage of time shall be treated as absolute claims are treated, except that such claims may be discounted at the legal rate of interest.

(4) Claims made under employment contracts by directors, principal officers, or persons in fact performing similar functions or having similar

powers are limited to payment for services rendered prior to the issuance of any order of rehabilitation or liquidation under Section 83-24-25 or Section 83-24-35.

HISTORY: Laws, 1991, ch. 417, § 37, eff from and after passage (approved March 20, 1991).

Cross References — Deposit of unpaid funds with State Treasurer and escheat proceedings, see § 83-24-89.

§ 83-24-75. Third-party claim filed with liquidator; insured filing claim; claim subject to coverage by guaranty association.

(1) Whenever any third party asserts a cause of action against an insured of an insurer in liquidation, the third party may file a claim with the liquidator.

(2) Whether or not the third party files a claim, the insured may file a claim on his own behalf in the liquidation. If the insured fails to file a claim by the date for filing claims specified in the order of liquidation or within sixty (60) days after mailing of the notice required by Section 83-24-43, whichever is later, he is an unexcused late filer.

(3) The liquidator shall make his recommendations to the court under Section 83-24-83, for the allowance of an insured's claim under subsection (2) after consideration of the probable outcome of any pending action against the insured on which the claim is based, the probable damages recoverable in the action and the probable costs and expenses of defense. After allowance by the court, the liquidator shall withhold any dividends payable on the claim, pending the outcome of litigation and negotiation with the insured. Whenever it seems appropriate, he shall reconsider the claim on the basis of additional information and amend his recommendations to the court. The insured shall be afforded the same notice and opportunity to be heard on all changes in the recommendation as in its initial determination. The court may amend its allowance as it thinks appropriate. As claims against the insured are settled or barred, the insured shall be paid from the amount withheld the same percentage dividend as was paid on other claims of like property, based on the lesser of (a) the amount actually recovered from the insured by action or paid by agreement plus the reasonable costs and expense of defense, or (b) the amount allowed on the claims by the court. After all claims are settled or barred, any sum remaining from the amount withheld shall revert to the undistributed assets of the insurer. Delay in final payment under this subsection shall not be a reason for unreasonable delay of final distribution and discharge of the liquidator.

(4) If several claims founded upon one (1) policy are filed, whether by third parties or as claims by the insured under this section, and the aggregate allowed amount of the claims to which the same limit of liability in the policy is applicable exceeds that limit, each claim as allowed shall be reduced in the same proportion so that the total equals the policy limit. Claims by the insured

shall be evaluated as in subsection (3). If any insured's claim is subsequently reduced under subsection (3), the amount thus freed shall be apportioned ratably among the claims which have been reduced under this subsection.

(5) No claim may be presented under this section if it is or may be covered by any guaranty association or foreign guaranty association.

HISTORY: Laws, 1991, ch. 417, § 38, eff from and after passage (approved March 20, 1991).

§ 83-24-77. Denial of claim; notice; objection to denial; hearing.

(1) When a claim is denied in whole or in part by the liquidator, written notice of the determination shall be given to the claimant or his attorney by first class mail at the address shown in the proof of claim. Within sixty (60) days from the mailing of the notice, the claimant may file his objections with the liquidator. If no such filing is made, the claimant may not further object to the determination.

(2) Whenever objections are filed with the liquidator and the liquidator does not alter his denial of the claim as a result of the objections, the liquidator shall ask the court for a hearing as soon as practicable and give notice of the hearing by first class mail to the claimant or his attorney and to any other persons directly affected not less than ten (10) nor more than thirty (30) days before the date of the hearing. The matter may be heard by the court or by a court-appointed referee who shall submit findings of fact along with his recommendation.

HISTORY: Laws, 1991, ch. 417, § 39, eff from and after passage (approved March 20, 1991).

Cross References — Resolving disputes as to claims, see § 83-24-85.

Claims by residents of Mississippi in liquidation proceeding in reciprocal state against insurer domiciled in that state, see § 83-24-111.

§ 83-24-79. Failure of secured creditor to file claim; distribution on claim.

Whenever a creditor whose claim against an insurer is secured, in whole or in part, by the undertaking of another person, fails to prove and file that claim, the other person may do so in the creditor's name, and shall be subrogated to the rights of the creditor, whether the claim has been filed by the creditor or by the other person in the creditor's name, to the extent that he discharges the undertaking. In the absence of an agreement with the creditor to the contrary, the other person shall not be entitled to any distribution; however, until the amount paid to the creditor on the undertaking plus the distributions paid on the claim from the insurer's estate to the creditor equals the amount of the entire claim of the creditor. Any excess received by the creditor shall be held by him in trust for such other person. The term "other person," as used in this section is not intended to apply to a guaranty association or foreign guaranty association.

HISTORY: Laws, 1991, ch. 417, § 40, eff from and after passage (approved March 20, 1991).

Cross References — Filing proof of claims, see § 83-24-69.

§ 83-24-81. Value of security held by secured creditor; determination.

(1) The value of any security held by a secured creditor shall be determined in one of the following ways, as the court may direct:

(a) By converting the same into money according to the terms of the agreement pursuant to which the security was delivered to such creditors; or

(b) By agreement, arbitration, compromise or litigation between the creditor and the liquidator.

(2) The determination shall be under the supervision and control of the court with due regard for the recommendation of the liquidator. The amount so determined shall be credited upon the secured claim, and any deficiency shall be treated as an unsecured claim. If the claimant shall surrender his security to the liquidator, the entire claim shall be allowed as if unsecured.

HISTORY: Laws, 1991, ch. 417, § 41, eff from and after passage (approved March 20, 1991).

Cross References — Filing proof of claims, see § 83-24-69.

Liquidation proceeding in Mississippi involving one or more reciprocal states, see § 83-24-115.

§ 83-24-83. Priority of distribution of claims; order of distribution.

The priority of distribution of claims from the insurer's estate shall be in accordance with the order in which each class of claims is herein set forth. Every claim in each class shall be paid in full or adequate funds retained for such payment before the members of the next class receive any payment. No subclasses shall be established within any class. The order of distribution of claims shall be:

(1) **Class 1.** The costs and expenses of administration during rehabilitation and liquidation, including but not limited to the following:

(a) The actual and necessary costs of preserving or recovering the assets of the insurer;

(b) Compensation for all authorized services rendered in the rehabilitation and liquidation;

(c) Any necessary filing fees;

(d) The fees and mileage payable to witnesses;

(e) Authorized reasonable attorney's fees and other professional services rendered in the rehabilitation and liquidation;

(f) The reasonable expenses of a guaranty association or foreign guaranty association for unallocated loss adjustment expenses.

(2) **Class 2.** All claims under policies including such claims of the federal or any state or local government for losses incurred ("loss claims") including third-party claims and all claims of a guaranty association or foreign guaranty association. All claims under life insurance and annuity policies, whether for death proceeds, annuity proceeds or investment values shall be treated as loss claims. That portion of any loss, indemnification for which is provided by other benefits or advantages recovered by the claimant, shall not be included in this class, other than benefits or advantages recovered or recoverable in discharge of familial obligation of support or by way of succession at death or as proceeds of life insurance, or as gratuities. No payment by an employer to his employee shall be treated as a gratuity.

(3) **Class 3.** Claims under nonassessable policies for unearned premium or other premium refunds.

(4) **Class 4.** Claims of the federal government not included in Class 2 or 3 above.

(5) **Class 5.** Reasonable compensation to employees for services performed to the extent that they do not exceed two (2) months of monetary compensation and represent payment for services performed within one (1) year before the filing of the petition for liquidation or, if rehabilitation preceded liquidation, within one (1) year before the filing of the petition for rehabilitation. Principal officers and directors shall not be entitled to the benefit of this priority except as otherwise approved by the liquidator and the court. Such priority shall be in lieu of any other similar priority which may be authorized by law as to wages or compensation of employees.

(6) **Class 6.** Claims of general creditors including claims of ceding and assuming companies in their capacity as such.

(7) **Class 7.** Claims of any state or local government except those under Class 2 or 3 above. Claims, including those of any state or local governmental body for a penalty or forfeiture, shall be allowed in this class only to the extent of the pecuniary loss sustained from the act, transaction, or proceeding out of which the penalty or forfeiture arose, with reasonable and actual costs occasioned thereby. The remainder of such claims shall be postponed to the class of claims under subsection (10).

(8) **Class 8.** Claims filed late or any other claims other than claims under subsections (9) and (10).

(9) **Class 9.** Surplus or contribution notes, or similar obligations, and premium refunds on assessable policies. Payments to members of domestic mutual insurance companies shall be limited in accordance with law.

(10) **Class 10.** The claims of shareholders or other owners in their capacity as shareholders.

HISTORY: Laws, 1991, ch. 417, § 42; Laws, 2000, ch. 431, § 1, eff from and after passage (approved Apr. 18, 2000).

Editor's Notes — Laws of 2000, ch. 431, § 2, provides:
"SECTION 2. It is the intent of the Legislature that Section 83-24-83 as amended by this act applies to pending and future claims in existing delinquency proceedings as

well as to claims in delinquency proceedings arising after the effective date of this act; that, in light of the ruling of the United States Supreme Court in U.S. Department of the Treasury v. Fabe, 113 S.Ct. 2202 (1993), the Legislature considers this act to be curative, remedial and not affecting substantive rights in the distribution of assets in delinquency proceedings; that this act is necessary to cure any potential defect in the present priority of distribution scheme that may result from the Fabe decision and to preserve the original intent of the Legislature with regard to the priorities of payment in delinquency proceedings."

Laws of 2000, ch. 431, § 3, provides:

"SECTION 3. If any classification or priority provided for in Section 1 of this act is held to be unconstitutional or otherwise invalid, the remaining classifications and priorities shall continue in effect."

Cross References — Powers and duties of liquidator, see § 83-24-41.

Disbursement of assets after final determination of insolvency, see § 83-24-67.

Filing proof of claims, see § 83-24-69.

Content of proof of claims, see § 83-24-71.

Claim filed by insurer, see § 83-24-75.

Payment of distributions, see § 83-24-87.

Deposit of unpaid funds with State Treasurer and escheat proceedings, see § 83-24-89.

Claims belonging to claimants residing in reciprocal states, see § 83-24-109.

§ 83-24-85. Review of claims filed in liquidation; reports; power and duty of court.

(1) The liquidator shall review all claims duly filed in the liquidation and shall make such further investigation as he shall deem necessary. He may compound, compromise or in any other manner negotiate the amount for which claims will be recommended to the court except when the liquidator is required by law to accept claims as settled by any person or organization, including any guaranty association or foreign guaranty association. Unresolved disputes shall be determined under Section 83-24-77. As soon as practicable, he shall present to the court a report of the claims against the insurer with his recommendations. The report shall include the name and address of each claimant and the amount of the claim finally recommended, if any. If the insurer has issued annuities or life insurance policies, the liquidator shall report the persons to whom, according to the records of the insurer, amounts are owed as cash surrender values or other investment value and the amounts owed.

(2) The court may approve, disapprove or modify the report on claims by the liquidator. Such reports as are not modified by the court within a period of sixty (60) days following submission by the liquidator shall be treated by the liquidator as allowed claims, subject thereafter to later modification or to rulings made by the court pursuant to Section 83-24-77. No claim under a policy of insurance shall be allowed for an amount in excess of the applicable policy limits.

HISTORY: Laws, 1991, ch. 417, § 43, eff from and after passage (approved March 20, 1991).

Cross References — Claims by residents of Mississippi in liquidation proceeding in reciprocal state against insurer domiciled in that state, see § 83-24-111.

§ 83-24-87. Payment of distributions.

Under the direction of the court, the liquidator shall pay distributions in a manner that will assure the proper recognition of priorities and a reasonable balance between the expeditious completion of the liquidation and the protection of unliquidated and undetermined claims, including third-party claims. Distribution of assets in kind may be made at valuations set by agreement between the liquidator and the creditor and approved by the court.

HISTORY: Laws, 1991, ch. 417, § 44, eff from and after passage (approved March 20, 1991).

Cross References — Priority of distribution of claims, see § 83-24-83.

§ 83-24-89. Deposit of unpaid funds with State Treasurer; escheat proceedings.

(1) All unclaimed funds subject to distribution remaining in the liquidator's hands when he is ready to apply to the court for discharge, including the amount distributable to any creditor, shareholder, member or other person who is unknown or cannot be found, shall be deposited with the State Treasurer, and shall be paid without interest except in accordance with Section 83-24-83 to the person entitled thereto or his legal representative upon proof satisfactory to the State Treasurer of his right thereto. Any amount on deposit not claimed within six (6) years from the discharge of the liquidator shall be deemed to have been abandoned and shall be escheated without formal escheat proceedings and shall be deposited into the General Fund.

(2) All funds withheld under Section 83-24-73 and not distributed shall upon discharge of the liquidator be deposited with the State Treasurer and paid by him in accordance with Section 83-24-83. Any sums remaining which under Section 83-24-83 would revert to the undistributed assets of the insurer shall be transferred to the State Treasurer and become the property of the state under subsection (1), unless the commissioner, in his discretion, petitions the court to reopen the liquidation under Section 83-24-93.

HISTORY: Laws, 1991, ch. 417, § 45, eff from and after passage (approved March 20, 1991).

§ 83-24-91. Application for order of discharge; costs and expenses.

(1) When all assets justifying the expense of collection and distribution have been collected and distributed under this chapter, the liquidator shall apply to the court for discharge. The court may grant the discharge and make any other orders, including an order to transfer any remaining funds that are uneconomic to distribute, as may be deemed appropriate.

(2) Any other person may apply to the court at any time for an order under subsection (1). If the application is denied, the applicant shall pay the costs and

expenses of the liquidator in resisting the application, including a reasonable attorney's fee.

HISTORY: Laws, 1991, ch. 417, § 46, eff from and after passage (approved March 20, 1991).

§ 83-24-93. Reopening proceedings after discharge of liquidator; orders.

After the liquidation proceeding has been terminated and the liquidator discharged, the commissioner or other interested party may at any time petition the court to reopen the proceedings for good cause, including the discovery of additional assets. If the court is satisfied that there is justification for reopening, it shall so order.

HISTORY: Laws, 1991, ch. 417, § 47, eff from and after passage (approved March 20, 1991).

Cross References — Deposit of unpaid funds with State Treasurer and escheat proceedings, see § 83-24-89.

§ 83-24-95. Destruction of records.

Whenever it shall appear to the commissioner that the records of any insurer in process of liquidation or completely liquidated are no longer useful, he may recommend to the court and the court shall direct what records should be retained for future reference and what should be destroyed.

HISTORY: Laws, 1991, ch. 417, § 48, eff from and after passage (approved March 20, 1991).

§ 83-24-97. Audit of books of commissioner relating to receivership established under this chapter; reports; expenses.

The court may, as it deems desirable, cause audits to be made of the books of the commissioner relating to any receivership established under this chapter, and a report of each audit shall be filed with the commissioner and with the court. The books, records and other documents of the receivership shall be made available to the auditor at any time without notice. The expense of each audit shall be considered a cost of administration of the receivership.

HISTORY: Laws, 1991, ch. 417, § 49, eff from and after passage (approved March 20, 1991).

§ 83-24-99. Commissioner of insurance acting as conservator in absence of appointment of domiciliary liquidator; orders.

(1) If a domiciliary liquidator has not been appointed, the commissioner may apply to the court by verified petition for an order directing him to act as

conservator to conserve the property of an alien insurer not domiciled in this state or a foreign insurer on any one or more of the following grounds:

(a) Any of the grounds in Section 83-24-23;

(b) That any of the insurer's property has been sequestered by official action in its domiciliary state, or in any other state;

(c) That enough of the insurer's property has been sequestered in a foreign country to give reasonable cause to fear that the insurer is or may become insolvent;

(d)(i) That the insurer's certificate of authority to do business in this state has been revoked or that none was ever issued; and

(ii) That there are residents of this state with outstanding claims or outstanding policies.

(2) When an order is sought under subsection (1), the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(3) The court may issue the order in whatever terms it shall deem appropriate. The filing or recording of the order with the Clerk of the Chancery Court of the First Judicial District of Hinds County or of the county in which the principal business of the company is located shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that chancery court would have imparted.

(4) The conservator may at any time petition for and the court may grant an order under Section 83-24-101 to liquidate assets of a foreign or alien insurer under conservation, or, if appropriate, for an order under Section 83-24-105 to be appointed ancillary receiver.

(5) The conservator may at any time petition the court for an order terminating conservation of an insurer. If the court finds that the conservation is no longer necessary, it shall order that the insurer be restored to possession of its property and the control of its business. The court may also make such finding and issue such order at any time upon motion of any interested party, but if such motion is denied all costs shall be assessed against such party.

HISTORY: Laws, 1991, ch. 417, § 50, eff from and after passage (approved March 20, 1991).

Cross References — Application by commissioner for order permitting liquidation of assets, see § 83-24-101.

Vesting title to assets in liquidator, see § 83-24-103.

RESEARCH REFERENCES

ALR.

Dissolving or winding up affairs of corporation domiciled in another state. 19 A.L.R.3d 1279.

Am. Jur.

36 Am. Jur. 2d, Foreign Corporations §§ 413 et seq.

CJS.

20 C.J.S., Foreign Corporations §§ 1898 et seq.

§ 83-24-101. Application by commissioner for order permitting liquidation of assets found in state of foreign insurer or alien insurer not domiciled in state; notice; filing or recording order; domiciliary liquidator appointed in reciprocal state or nonreciprocal state; payment of claims.

(1) If no domiciliary receiver has been appointed, the commissioner may apply to the court by verified petition for an order directing him to liquidate the assets found in this state of a foreign insurer or an alien insurer not domiciled in this state, on any of the following grounds:

(i) Any of the grounds in Section 83-24-23 or 83-24-33; or

(ii) Any of the grounds specified in Section 83-24-99(1)(b) through (d).

(2) When an order is sought under subsection (1), the court shall cause the insurer to be given such notice and time to respond thereto as is reasonable under the circumstances.

(3) If it shall appear to the court that the best interests of creditors, policyholders and the public require, the court may issue an order to liquidate in whatever terms it shall deem appropriate. The filing or recording of the order with the Clerk of the Chancery Court of the First Judicial District of Hinds County or of the county in which the principal business of the company is located or the county in which its principal office or place of business is located, shall impart the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that chancery court would have imparted.

(4) If a domiciliary liquidator is appointed in a reciprocal state while a liquidation is proceeding under this section, the liquidator under this section shall thereafter act as ancillary receiver under Section 83-24-105. If a domiciliary liquidator is appointed in a nonreciprocal state while a liquidation is proceeding under this section, the liquidator under this section may petition the court for permission to act as ancillary receiver under Section 83-24-105.

(5) On the same grounds as are specified in subsection (1), the commissioner may petition any appropriate federal district court to be appointed receiver to liquidate that portion of the insurer's assets and business over which the court will exercise jurisdiction, or any lesser part thereof that the commissioner deems desirable for the protection of the policyholders and creditors in this state.

(6) The court may order the commissioner, when he has liquidated the assets of a foreign or alien insurer under this section, to pay claims of residents of this state against the insurer under such rules as to the liquidation of insurers under this chapter as are otherwise compatible with the provisions of this section.

HISTORY: Laws, 1991, ch. 417, § 51, eff from and after passage (approved March 20, 1991).

Cross References — Commissioner of insurance acting as conservator in absence of appointment of domiciliary liquidator, see § 83-24-99.

Vesting title to assets in liquidator, see § 83-24-103.

§ 83-24-103. Vesting of title to assets in liquidator; filing claim with liquidator or ancillary receiver.

(1) The domiciliary liquidator of an insurer domiciled in a reciprocal state shall, except as to special deposits and security on secured claims under Section 83-24-105(3), be vested by operation of law with the title to all of the assets, property, contracts and rights of action, agents' balances, and all of the books, accounts and other records of the insurer located in this state. The date of vesting shall be the date of the filing of the petition, if that date is specified by the domiciliary law for the vesting of property in the domiciliary state. Otherwise, the date of vesting shall be the date of entry of the order directing possession to be taken. The domiciliary liquidator shall have the immediate right to recover balances due from agents and to obtain possession of the books, accounts and other records of the insurer located in this state. He also shall have the right to recover all other assets of the insurer located in this state, subject to Section 83-24-105.

(2) If a domiciliary liquidator is appointed for an insurer not domiciled in a reciprocal state, the commissioner of this state shall be vested by operation of law with the title to all of the property, contracts and right of action, and all of the books, accounts and other records of the insurer located in this state, at the same time that the domiciliary liquidator is vested with title in the domicile. The commissioner of this state may petition for a conservation or liquidation order under Section 83-24-99 or 83-24-101, or for an ancillary receivership under Section 83-24-105 or after approval by the court may transfer title to the domiciliary liquidator, as the interests of justice and the equitable distribution of the assets require.

(3) Claimants residing in this state may file claims with the liquidator or ancillary receiver, if any, in this state or with the domiciliary liquidator, if the domiciliary law permits. The claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceedings.

HISTORY: Laws, 1991, ch. 417, § 52, eff from and after passage (approved March 20, 1991).

Cross References — Reciprocal state, defined, see § 83-24-7.

§ 83-24-105. Petition for appointment as ancillary receiver; orders.

(1) If a domiciliary liquidator has been appointed for an insurer not domiciled in this state, the commissioner may file a petition with the court requesting appointment as ancillary receiver in this state:

(a) If he finds that there are sufficient assets of the insurer located in this state to justify the appointment of an ancillary receiver;

(b) If the protection of creditors or policyholders in this state so requires.

(2) The court may issue an order appointing an ancillary receiver in whatever terms it shall deem appropriate. The filing or recording of the order

with the chancery court in this state imparts the same notice as a deed, bill of sale or other evidence of title duly filed or recorded with that chancery court.

(3) When a domiciliary liquidator has been appointed in a reciprocal state, then the ancillary receiver appointed in this state may, whenever necessary, aid and assist the domiciliary liquidator in recovering assets of the insurer located in this state. The ancillary receiver shall, as soon as practicable, liquidate from their respective securities those special deposit claims and secured claims which are proved and allowed in the ancillary proceedings in this state, and shall pay the necessary expenses of the proceedings. He shall promptly transfer all remaining assets, books, accounts and records to the domiciliary liquidator. Subject to this section, the ancillary receiver and his deputies shall have the same powers and be subject to the same duties with respect to the administration of assets as a liquidator of an insurer domiciled in this state.

(4) When a domiciliary liquidator has been appointed in this state, ancillary receivers appointed in reciprocal states shall have, as to assets and books, accounts, and other records in their respective states, corresponding rights, duties and powers to those provided in subsection (3) for ancillary receivers appointed in this state.

HISTORY: Laws, 1991, ch. 417, § 53, eff from and after passage (approved March 20, 1991).

Cross References — Reciprocal state, defined, see § 83-24-7.

Commissioner of insurance acting as conservator in absence of appointment of domiciliary liquidator, see § 83-24-99.

Application by commissioner for order permitting liquidation of assets, see § 83-24-101.

Vesting title to assets in liquidator, see § 83-24-103.

§ 83-24-107. Discretion of commissioner of insurance to institute proceedings.

The commissioner in his sole discretion may institute proceedings under Sections 83-24-19 and 83-24-21 at the request of the commissioner or other appropriate insurance official of the domiciliary state of any foreign or alien insurer having property located in this state.

HISTORY: Laws, 1991, ch. 417, § 54, eff from and after passage (approved March 20, 1991).

§ 83-24-109. Claimants residing in foreign country or in states not reciprocal states; time requirements; notice; claims by claimants residing in reciprocal states.

(1) In a liquidation proceeding begun in this state against an insurer domiciled in this state, claimants residing in foreign countries or in states not reciprocal states must file claims in this state, and claimants residing in reciprocal states may file claims either with the ancillary receivers, if any, in

their respective states, or with the domiciliary liquidator. Claims must be filed on or before the last date fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in reciprocal states may be proved either in the liquidation proceeding in this state as provided in this chapter, or in ancillary proceedings, if any, in the reciprocal states. If notice of the claims and opportunity to appear and be heard is afforded the domiciliary liquidator of this state as provided in Section 83-24-111(2) with respect to ancillary proceedings, the final allowance of claims by the courts in ancillary proceedings in reciprocal states shall be conclusive as to amount and as to priority against special deposits or other security located in such ancillary states, but shall not be conclusive with respect to priorities against general assets under Section 83-24-83.

HISTORY: Laws, 1991, ch. 417, § 55, eff from and after passage (approved March 20, 1991).

Cross References — Reciprocal state, defined, see § 83-24-7.
Filing proof of claims, see § 83-24-69.
Contents of proof of claims, see § 83-24-71.

§ 83-24-111. Liquidation proceeding in reciprocal state against insurer domiciled in that state; claims by residents of Mississippi; notice; hearings; final allowance.

(1) In a liquidation proceeding in a reciprocal state against an insurer domiciled in that state, claimants against the insurer who reside within this state may file claims either with the ancillary receiver, if any, in this state, or with the domiciliary liquidator. Claims must be filed on or before the last dates fixed for the filing of claims in the domiciliary liquidation proceeding.

(2) Claims belonging to claimants residing in this state may be proved either in the domiciliary state under the law of that state, or in ancillary proceedings, if any, in this state. If a claimant elects to prove his claim in this state, he shall file his claim with the liquidator in the manner provided in Sections 83-24-69 and 83-24-71. The ancillary receiver shall make his recommendation to the court as under Section 83-24-85. He shall also arrange a date for hearing if necessary under Section 83-24-77 and shall give notice to the liquidator in the domiciliary state, either by certified mail or by personal service at least forty (40) days prior to the date set for hearing. If the domiciliary liquidator, within thirty (30) days after the giving of such notice, gives notice in writing to the ancillary receiver and to the claimant, either by certified mail or by personal service, of his intention to contest the claim, he shall be entitled to appear or to be represented in any proceeding in this state involving the adjudication of the claim.

(3) The final allowance of the claim by the courts of this state shall be accepted as conclusive as to amount and as to priority against special deposits or other security located in this state.

HISTORY: Laws, 1991, ch. 417, § 56, eff from and after passage (approved March 20, 1991).

Cross References — Reciprocal state, defined, see § 83-24-7.
Filing proof of claims, see § 83-24-69.
Contents of proof of claims, see § 83-24-71.
Claims belonging to claimants residing in reciprocal states, see § 83-24-109.

§ 83-24-113. Attachment, garnishment or levy of execution against delinquent insurer during pendency of liquidation proceedings.

During the pendency in this or any other state of a liquidation proceeding, whether called by that name or not, no action or proceeding in the nature of an attachment, garnishment or levy of execution shall be commenced or maintained in this state against the delinquent insurer or its assets.

HISTORY: Laws, 1991, ch. 417, § 57, eff from and after passage (approved March 20, 1991).

Cross References — Reciprocal state, defined, see § 83-24-7.

§ 83-24-115. Liquidation proceeding in Mississippi involving one or more reciprocal states; order of distribution; priority of claims; special deposit claims; surrender of secured claim.

(1) In a liquidation proceeding in this state involving one or more reciprocal states, the order of distribution of the domiciliary state shall control as to all claims of residents of this and reciprocal states. All claims of residents of reciprocal states shall be given equal priority of payment from general assets regardless of where such assets are located.

(2) The owners of special deposit claims against an insurer for which a liquidator is appointed in this or any other state shall be given priority against the special deposits in accordance with the statutes governing the creation and maintenance of the deposits. If there is a deficiency in any deposit, so that the claims secured by it are not fully discharged from it, the claimants may share in the general assets, but the sharing shall be deferred until general creditors, and also claimants against other special deposits who have received smaller percentages from their respective special deposits, have been paid percentages of their claims equal to the percentage paid from the special deposit.

(3) The owner of a secure claim against an insurer for which a liquidator has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security in accordance with Section 83-24-81, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors.

HISTORY: Laws, 1991, ch. 417, § 58, eff from and after passage (approved March 20, 1991).

Cross References — Priority of distribution of claims, see § 83-24-83.

§ 83-24-117. Failure of ancillary receiver in another state or foreign country to transfer assets to domiciliary liquidator.

If an ancillary receiver in another state or foreign country, whether called by that name or not, fails to transfer to the domiciliary liquidator in this state any assets within his control other than special deposits, diminished only by the expenses of the ancillary receivership, if any, the claims filed in the ancillary receivership, other than special deposit claims or secured claims, shall be placed in the class of claims under Section 83-24-83(7).

HISTORY: Laws, 1991, ch. 417, § 59, eff from and after passage (approved March 20, 1991).

Cross References — Priority of distribution of claims, see § 83-24-83.

Failure of ancillary receiver in another state or foreign country to transfer assets to domiciliary liquidator, see § 83-24-117.

CHAPTER 25.

CO-OPERATIVE INSURANCE

Sec.
83-25-1. Charter, bylaws, rules, to be filed with commissioner.
83-25-3. Policies to agree with charter and bylaws.
83-25-5. Report and publication.

§ 83-25-1. Charter, bylaws, rules, to be filed with commissioner.

Every corporation, company, society, organization, or association of this or of any other state or country transacting the business of life insurance upon the co-operative or assessment plan shall file with the commissioner of insurance, before commencing to do business in this state, a copy of its charter or articles of association, as well as the bylaws, rules, or regulations referred to in its policies or certificates and made a part of said contract. No bylaws or regulations, unless so filed with the commissioner, shall operate to avoid or affect any policy or certificate issued by such company or association.

HISTORY: Codes, 1906, § 2636; Hemingway's 1917, § 5102; 1930, § 5180; 1942, § 5690.

RESEARCH REFERENCES

CJS.
44 C.J.S., Insurance §§ 579 et seq.

§ 83-25-3. Policies to agree with charter and bylaws.

Every policy or certificate or renewal receipt issued to a resident of the State of Mississippi by any corporation, association, or order therein transacting the business of life insurance upon the assessment plan shall be in accord with the provisions of the charter and bylaws of said corporation, association, or order, as filed with the commissioner of insurance. It shall be unlawful for any domestic or foreign insurance company or fraternal order to transact or offer to transact any business not authorized by the provisions of their charter and the terms of their bylaws, or through an agent, or otherwise to offer or issue any policy, renewal, certificate, or other contract, the terms of which are not in clear accord with the powers, terms, and stipulations of their charters and bylaws. Upon a proper application by any citizen of this state, it shall be the duty of the commissioner to give a statement or synopsis of the provisions of any insurance contract offered or issued to such citizen. If any such corporation or association or order shall at any time fail or refuse to comply with the provisions of this section, the commissioner shall forthwith suspend or revoke all authority to such corporation, association, or order, and all its agents or officers to do business in this state, and shall publish such revocation in some newspaper published in this state.

HISTORY: Codes, 1906, § 2635; Hemingway's 1917, § 5101; 1930, § 5179; 1942, § 5689.

Cross References — Requirement of certain words and language in every life insurance policy, see § 83-7-17.

Personal liability of insurance agent, see § 83-17-3.

Benefits payable by fraternal societies, see § 83-29-9.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 67, 68.

CJS.
44 C.J.S., Insurance §§ 91, 92.

§ 83-25-5. Report and publication.

Every corporation, company, society, organization, or association of this or any other state or country transacting the business of life insurance on the co-operative or assessment plan shall, on or before the first day of March of each year, make and file with the commissioner of insurance a report of its affairs and operations during the year ending on the 31st day of December immediately preceding. Such report shall be upon blank forms to be provided by the commissioner; and shall be verified under oath by the duly authorized officers of such corporation, society, order, or association; shall be published, or the substance thereof, in some newspaper published in the state at the expense of said company, corporation, order, etc., and in his annual report by the commissioner under a separate part, entitled "Assessment Companies or Associations"; and shall contain such information as the commissioner in his judgment may deem necessary for the welfare of the people of the state, subject to like penalties imposed in Section 83-5-69.

HISTORY: Codes, 1906, § 2634; Hemingway's 1917, § 5100; 1930, § 5178; 1942, § 5688.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance § 96.

CHAPTER 27.

SURETY COMPANIES

Sec.	
83-27-1.	Accepted as sureties on bonds.
83-27-3.	Must show compliance with law.
83-27-5.	Capital of $100,000 in securities required.
83-27-7.	Agents.
83-27-9.	Liability limited to one tenth of capital and surplus.
83-27-11.	Estopped to deny corporate powers.

§ 83-27-1. Accepted as sureties on bonds.

Any company incorporated and organized under the laws of any state of the United States for the purpose of transacting business as surety on obligations of persons or corporations, which has complied with all the requirements of this chapter may be accepted as surety in part, or as sole surety, upon the bond of any person, officer or corporation required by the laws of this state to execute a bond or bonds. Such company may be substituted as sole surety or as co-surety for a surety or sureties on bonds already given, and may be released from liability on the same terms and conditions as are by law prescribed for the substitution and release of individuals as sureties. Where a surety company subscribes to a bond, it shall not be necessary that there shall be additional sureties. In all cases where such company shall become surety for part only of any bond, its liability on such bond shall be limited to the amount for which it becomes surety. All surety companies shall possess the capital and surplus requirements as required in Sections 83-19-31 and 83-21-3.

HISTORY: Codes, 1906, § 2669; Hemingway's 1917, § 5135; 1930, § 5225; 1942, § 5739; Laws, 1896, ch. 55; Laws, 1997, ch. 410, § 18, eff from and after July 1, 1997.

Cross References — Constitutional authority for acceptance of surety company on official bond, see MS Const Art. 4, § 82.

Statutory requirement of surety bonds for state officials, see § 25-1-13.

Procedure for release from official bond, see § 25-1-29.

Surety bonds for employees of common carriers, see §§ 77-9-27 et seq.

Action by surety company against defaulting principal, see §§ 87-5-5 et seq.

RESEARCH REFERENCES

ALR.

Fidelity bond termination clause on taking over of insured by another business entity: construction and effect. 44 A.L.R.4th 1195.

Am. Jur.

74 Am. Jur. 2d, Suretyship § 202.

CJS.

44 C.J.S., Insurance §§ 76-80.

§ 83-27-3. Must show compliance with law.

Before such company shall be accepted as surety, it shall produce to the judge, head of department, or other officer authorized to approve such bond satisfactory evidence of its compliance with and fulfillment of all the requirements of this chapter.

HISTORY: Codes, 1906, § 2670; Hemingway's 1917, § 5136; 1930, § 5226; 1942, § 5740; Laws, 1894, ch. 64.

RESEARCH REFERENCES

Am. Jur.	CJS.
74 Am. Jur. 2d, Suretyship § 202.	44 C.J.S., Insurance §§ 76-80.

§ 83-27-5. Capital of $100,000 in securities required.

No such company shall be accepted as surety unless the amount of at least One Hundred Thousand Dollars ($100,000.00) of its said paid-up capital is invested in solvent securities created by the laws of the United States or of the State of Mississippi or by or under the laws of the state by which such company is incorporated, or in other safe securities the value of which, at the time of such acceptance, shall be at or above par and which are deposited with the insurance commissioner, auditor, comptroller, or chief financial officer of the state under whose laws such company is incorporated, and the commissioner of insurance of this state is furnished with the certificate of such commissioner, auditor, comptroller, or officer, under his hand and official seal that he, as said insurance commissioner, auditor, comptroller, or chief financial officer of said state holds the said securities in trust and on deposit for the benefit of such obligees of such company, which certificate shall describe the items of security so held and shall state that he is satisfied they are worth One Hundred Thousand Dollars ($100,000.00).

HISTORY: Codes, 1906, § 2671; Hemingway's 1917, § 5137; 1930, § 5227; 1942, § 5741.

Cross References — Limitation of liability, see § 83-27-9.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 72.	44 C.J.S., Insurance §§ 121-123.

§ 83-27-7. Agents.

Every person who shall so represent any such company as to receive or transmit applications for suretyship, or to receive for delivery bonds founded on applications from this state, or otherwise to procure suretyship to be effected by said company upon the bonds of persons or corporations in this state, or upon bonds given to persons or corporations in this state, shall be deemed as an agent for such company. No person shall act as agent for such company until such company shall have complied with all of the requirements of this chapter, under penalty of a fine of One Thousand Dollars ($1,000.00).

HISTORY: Codes, 1906, § 2672; Hemingway's 1917, § 5138; 1930, § 5228; 1942, § 5742.

Cross References — Definition of insurance agent generally, see § 83-17-1.

JUDICIAL DECISIONS

1. In general.

Where agent of surety company delivered appeal bond as company's bond, company was estopped from denying agent's authority or that signature was not binding on them. Champenois & Blanks v. Donald Co., 153 Miss. 719, 121 So. 485, 1929 Miss. LEXIS 77 (Miss. 1929).

RESEARCH REFERENCES

Am. Jur.

74 Am. Jur. 2d, Suretyship § 203.

CJS.

44 C.J.S., Insurance § 138.

§ 83-27-9. Liability limited to one tenth of capital and surplus.

No company shall be accepted as surety on any bond for an amount larger than one tenth (1⁄10) of the company's paid-up capital and surplus as reflected in its last annual statement, unless it shall be secured from loss beyond such amount by reinsurance in an authorized company or by the amount of any cosuretyship, provided such reinsurance or cosurety shall not exceed the limits set forth herein for the prime surety, or by the value of any security deposited, pledged, or held subject to the company's consent and for its protection.

HISTORY: Codes, 1906, § 2673; Hemingway's 1917, § 5139; 1930, § 5229; 1942, § 5743; Laws, 1970, ch. 453, § 1, eff from and after passage (approved March 24, 1970).

Cross References — Required deposit of securities, see § 83-27-5.

RESEARCH REFERENCES

Am. Jur.

44A Am. Jur. 2d, Insurance §§ 1842 et seq.

CJS.

46 C.J.S., Insurance §§ 1720 et seq.

§ 83-27-11. Estopped to deny corporate powers.

Any company who shall execute any bond as surety shall, in any proceeding to enforce the liability which it shall have assumed to incur, be estopped to deny its corporate power to execute such instrument or assume such liability. Nor shall any failure to comply with any or all of the provisions of this chapter avail said company as a defense in any such proceedings.

HISTORY: Codes, 1906, § 2674; Hemingway's 1917, § 5140; 1930, § 5230; 1942, § 5744.

RESEARCH REFERENCES

Am. Jur.

44 Am. Jur. 2d, Insurance § 1058, 1060, 1061.

CJS.

45 C.J.S., Insurance § 1012-1014.

CHAPTER 29.

FRATERNAL SOCIETIES

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§ 83-29-1. Fraternal benefit societies defined.

Any corporation, society, order, or voluntary association without capital stock, organized and carried on solely for the mutual benefit of its members and their beneficiaries and not for profit, and having less than Thirty Thousand Dollars ($30,000.00) in total annual written premium, having a lodge system and representative form of government, or which limits its membership to a secret fraternity having a lodge system and representative form of government, and which shall make provision for the payment of benefits in accordance with Section 83-29-9 is hereby declared to be a fraternal benefit society.

HISTORY: Codes, 1930, § 5231; 1942, § 5745; Laws, 2001, ch. 362, § 42, eff from and after July 1, 2001.

Cross References — Administrative supervision of insurers by Commissioner of Insurance, see §§ 83-1-151 et seq.

Exclusion of fraternal benefit society from requirement of minimum surplus, see § 83-19-77.

Larger fraternal benefit societies defined, see §§ 83-30-1 et seq.

RESEARCH REFERENCES

Am. Jur.

36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 1 and 2.

12 Am. Jur. Pl & Pr Forms (Rev), Fraternal Orders and Benefit Societies, Forms 1 et seq. (actions to recover on benefit certificates or policies; in general).

CJS.

10 C.J.S., Beneficial Associations § 1.

§ 83-29-3. Lodge system defined.

Any society having a supreme governing or legislative body and subordinate lodges or branches by whatever name known, into which members shall be admitted in accordance with its constitution, laws, ritual, rules, and regulations, and which shall be required by the laws of such society to hold periodical meetings, shall be deemed to be operating on the lodge system.

HISTORY: Codes, 1930, § 5232; 1942, § 5746.

Cross References — Definition of lodge system as it applies to larger fraternal benefit societies, see § 83-30-3.

RESEARCH REFERENCES

Am. Jur.

36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 1 and 2.

12 Am. Jur. Pl & Pr Forms (Rev), Fraternal Orders and Benefit Societies, Forms 71 et seq. (suspension or expulsion of subordinate lodges).

CJS.

10 C.J.S., Beneficial Associations § 4.

§ 83-29-5. Representative form of government defined.

Any society shall be deemed to have a representative form of government when it shall provide in its constitution and laws for a supreme legislative or governing body, composed of representatives elected either by the members or by delegates elected directly or indirectly by the members, together with such other members as may be prescribed by its constitution and laws. The elective members shall constitute a majority in number and not less than the number of votes required to amend its constitution and laws; and the meetings of the supreme or governing body, and the election of officers, representatives, or delegates shall be held as often as once in four (4) calendar years. No member under age sixteen (16) shall have a voice or vote in the management of the society. No member, officer, representative, or delegate shall vote by proxy.

HISTORY: Codes, 1930, § 5233; 1942, § 5747.

Cross References — Definition of representative form of government as it applies to larger fraternal benefit societies, see § 83-30-5.

RESEARCH REFERENCES

Am. Jur.
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 1 and 2.

CJS.
10 C.J.S., Beneficial Associations § 60.

§ 83-29-7. Exemptions.

Except as herein provided, such societies shall be governed by this chapter and shall be exempt from all provisions of the insurance laws of this state, not only in governmental relations with the state but for every other purpose. No law hereafter enacted shall apply to them unless they be expressly designated therein.

HISTORY: Codes, 1930, § 5234; 1942, § 5748.

Cross References — Laws applicable to domestic insurance companies, see § 83-5-13.

Exclusion of larger fraternal benefit societies from insurance laws of state, see § 83-30-45.

Exclusion of fraternal societies from laws governing burial associations, see § 83-37-33.

JUDICIAL DECISIONS

1. In general.

A conversion of a fraternal society into a mutual life and disability company destroyed the immunity provided by this section [Code 1942, § 5748]; and consequently, a mutual company, so converted, was bound by the acts of its agents in misleading an insured as to the extent of disability necessary to entitle him to file a claim therefor, the act of the agent in that regard being the act of the company itself, under Code 1930, § 5196 [Code 1942, § 5706]. Columbian Mut. Life Ins. Co. v. Gipson, 185 Miss. 890, 189 So. 799, 1939 Miss. LEXIS 192 (Miss. 1939).

RESEARCH REFERENCES

Am. Jur.
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 4-7.

CJS.
10 C.J.S., Beneficial Associations § 2.

§ 83-29-9. Benefits.

(1) Every society transacting business under this chapter may provide for the payments of benefits upon the death of its members either within a term

of years or at any time, may provide for benefits payable upon its members reaching seventy (70) years of age, may also provide for the payment of benefits in case of total and permanent disability, may provide also for the payment of benefits in the event of temporary disability, and may provide for monuments or tombstones to the memory of its deceased members and for the payment of funeral benefits.

(2) Any society may also enter into contracts in such other forms and granting such benefits as its laws may authorize when it shall provide for the accumulation and maintenance of assets required for the payment of such benefits when valued upon an interest basis not exceeding four percent (4%) per annum and mortality standards adopted by it within the limitations provided in the statutes relating to fraternal benefit societies or, at the option of the society, in the statutes relating to life insurance companies.

HISTORY: Codes, 1930, § 5235; 1942, § 5749; Laws, 1966, ch. 533, § 1, eff from and after passage (approved June 11, 1966).

Cross References — Life insurance generally, see §§ 83-7-1 et seq.

Requirement that contracts for benefits be authorized by charter and bylaws, see § 83-25-3.

RESEARCH REFERENCES

Am. Jur.

36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 82 et seq.

12 Am. Jur. Pl & Pr Forms (Rev), Fraternal Orders and Benefit Societies, Forms 1 et seq. (actions to recover on benefit certificates or policies; in general).

CJS.

10 C.J.S., Beneficial Associations §§ 34, 35.

§ 83-29-11. Members and beneficiaries.

Any person may be admitted to beneficial, or general, or social membership in any society in such manner and upon such showing of eligibility as the laws of the society may provide, and any beneficial member may direct any benefit to be paid to such person or persons, entity, or interest as may be permitted by the laws of the society. No beneficiary shall have or obtain any vested interest in the said benefit until the same has become due and payable in conformity with the provisions of the contract of membership, and the member shall have full right to change his beneficiary, or beneficiaries, in accordance with the laws, rules, and regulations of the society.

HISTORY: Codes, 1930, § 5236; 1942, § 5750.

JUDICIAL DECISIONS

1. In general.

Insured, as member of fraternal order, was subject to the constitution and bylaws thereof, and beneficiary could not recover for disability resulting from insured's insanity where payment of dues and installments were not continued and the notice of disability was not given the order as required by the constitution and the policy. Columbian Mut. Life Ins. Co. v. Eaves, 185 Miss. 127, 185 So. 557, 1939 Miss. LEXIS 112 (Miss. 1939).

RESEARCH REFERENCES

ALR.

Rights and liabilities arising out of contract for lifetime membership in social or fraternal club or association. 10 A.L.R.3d 1357.

Am. Jur.

36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 49 et seq., 129 et seq.

12 Am. Jur. Pl & Pr Forms (Rev), Fraternal Orders and Benefit Societies, Forms 21 et seq. (membership); 31 et seq. (beneficiaries).

CJS.

10 C.J.S., Beneficial Associations §§ 41 et seq.

§ 83-29-13. Certificate.

The certificate, the charter or articles of incorporation or, if a voluntary association, the articles of association, constitution and laws of the society, and the application for membership signed by the applicant, and all amendments to each thereof shall constitute the agreement between the society and the member; and copies of the same certified by the secretary of the society, or corresponding officer, shall be received in evidence of the terms and conditions thereof. Any changes, additions, or amendments to said charter or articles of incorporation, or articles of association, if a voluntary association, constitution or laws duly made or enacted subsequent to the issuance of the benefit certificate shall bind the member and his beneficiaries, and shall govern and control the agreement in all respects the same as though such changes, additions, or amendments had been made prior to and were in force at the time of the application for membership.

HISTORY: Codes, 1930, § 5237; 1942, § 5751.

RESEARCH REFERENCES

Am. Jur.

36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 10-12, 80 et seq.

CJS.

10 C.J.S., Beneficial Associations §§ 7-10, 34.

§ 83-29-15. Funds.

(1) Any society may create, maintain, invest, disburse, and apply an emergency, surplus, or other fund consistent with the purposes for which such society is organized, including hospital and health, home, thrift, pension for its employees, patriotic, educational, and relief funds, in accordance with its laws. Unless otherwise provided in the contract, such funds shall be held, invested, and disbursed for the use and benefit of the society, and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment or the surrender of any part thereof, except as provided in subsection (2) of Section 83-29-9. The funds from which benefits shall be

paid and the funds from which the expenses of the society shall be defrayed shall be derived from periodical or other payments by the members of the society and accretions of said funds. All societies hereafter incorporated or foreign societies hereafter admitted shall be one hundred percent (100%) solvent according to the valuation requirements of Section 83-29-43.

(2) Deferred payments of installments of claims shall be considered as fixed liabilities on the happening of the contingency upon which such payments or installments are thereafter to be paid. Such liability shall be the present value of such future payments or installments upon the rate of interest and mortality assumed by the society for valuations, and every society shall maintain a fund sufficient to meet such liability regardless of proposed future collections to meet any such liabilities.

HISTORY: Codes, 1930, § 5238; 1942, § 5752.

RESEARCH REFERENCES

Am. Jur.
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 23.

CJS.
10 C.J.S., Beneficial Associations § 32.

§ 83-29-17. Investments.

Every society shall invest its funds only in securities permitted by the laws of this state for the investment of the assets of life insurance companies, and such securities shall be valued according to the methods used in valuing similar securities held by life insurance companies. Any foreign society permitted or seeking to do business in this state, which invests its funds in accordance with the laws of the state in which it is incorporated, shall be held to meet the requirements of this chapter for the investment of funds.

HISTORY: Codes, 1930, § 5239; 1942, § 5753.

Cross References — Approved investments for funds of domestic insurance companies, see §§ 83-19-51, 83-19-53.

Approved investments for assets of larger fraternal benefit societies, see § 83-30-41.

Approved investments for assets of mutual companies, see § 83-31-29.

RESEARCH REFERENCES

Am. Jur.
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies, § 22.

CJS.
10 C.J.S., Beneficial Associations § 30.

§ 83-29-19. Distribution of funds.

(1) Every society which is one hundred percent (100%) solvent according to the requirements of Section 83-29-43 in respect of the whole society, or of a class or section thereof, shall collect sufficient periodical or other contributions from the members of the society, or of such class or section thereof, which, with

interest accretions, are sufficient to pay the claims arising from the certificates of the whole society, or of such class or section thereof, and its expenses, and to maintain a fund sufficient to meet its accrued liabilities and the reserves required to maintain the said percentage of solvency in accordance with the said Section 83-29-43 or, in lieu thereof, shall comply with subsection (2) of this section.

(2) Every other society, or other class or section thereof, shall collect from the members of such society, or other class or section thereof, stated periodical or other contributions expressly collected for the mortuary or disability funds, and periodical or other contributions expressly collected for the expense or management fund, both of which may be included in the periodical contribution. No part of the money collected for the mortuary or disability funds, or of the funds, or of the interest accretions thereto shall be used for expense purposes.

HISTORY: Codes, 1930, § 5240; 1942, § 5754.

RESEARCH REFERENCES

Am. Jur.
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 23.

CJS.
10 C.J.S., Beneficial Associations § 32.

§ 83-29-21. Organization.

Seven (7) or more persons, citizens of the United States and a majority of whom are citizens of this state, who desire to form a fraternal benefit society, as defined by this chapter, may make, sign, giving their addresses, and acknowledge, before some officer competent to take acknowledgment of deeds, article of incorporation in which shall be stated:

(a) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company already transacting business in this state as to mislead the public or to lead to confusion;

(b) The purpose for which it is formed – which shall not include more liberal powers than are granted by this chapter, provided that any lawful social, intellectual, educational, charitable, benevolent, moral, or religious advantages may be set forth among the purposes of the society – and the mode in which its corporate powers are to be exercised;

(c) The names, residences, and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control and management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme legislative or governing body, which election shall be held not later than one (1) year from the date of the issuance of the permanent certificate.

Such articles of incorporation, duly certified copies of the constitution and laws, rules and regulations, copies of all proposed forms of benefit certificates, applications therefor, circulars to be issued by such society, and a bond in the sum of Five Thousand Dollars ($5,000.00), with sureties approved by the commissioner of insurance, conditioned upon the return, as provided in this section, of the advance payments to applicants if the organization is not completed within one (1) year, shall be filed with the commissioner of insurance, who may require such further information as he deems necessary. If the purposes of the society conform to the requirements of this chapter and all provisions of law have been complied with, the commissioner of insurance shall so certify and retain and record, or file, the articles of incorporation, and furnish the incorporators a preliminary certificate authorizing said society to solicit members as hereinafter provided.

Upon receipt of said certificate from the commissioner of insurance, said society may solicit members for the purpose of completing its organization and shall collect from each applicant the amount of not less than one (1) regular monthly payment, in accordance with its table of rates as provided by its constitution and laws, and shall issue to each such applicant a receipt for the amount so collected. No such society shall incur any liability other than for such advanced payments, nor issue any benefit certificate, nor pay or allow, or offer or promise to pay or allow, to any person any death or disability benefit until actual bona fide applications for death benefit certificates have been secured upon at least five hundred (500) lives for at least One Thousand Dollars ($1,000.00) each, and all such applicants for death benefits shall have been regularly examined by legally qualified practicing physicians, and certificates of such examinations have been duly filed and approved by the chief medical examiner of such society; nor until there shall be established ten subordinate lodges or branches into which said five hundred (500) applicants have been initiated; nor until there has been submitted to the commissioner of insurance, under oath of the president and secretary or corresponding officers of such society, a list of such applicants, giving their names, addresses, date examined, date approved, date initiated, name and number of the subordinate branch of which each applicant is a member, amount of benefits to be granted, rate of stated periodical contributions which shall be sufficient to meet the requirements of subsection (1) of Section 83-29-19, nor until it shall be shown to the commissioner of insurance by the sworn statement of the treasurer or corresponding officer of such society that at least five hundred (500) applicants have each paid in cash at least one (1) regular monthly payment as herein provided for One Thousand Dollars ($1,000.00) of indemnity to be effected, which payments in the aggregate shall amount to at least Twenty-five Hundred Dollars ($2500.00); all of which shall be credited to the mortuary or disability fund on account of such applicants, and no part of which may be used for expenses.

Said advanced payments shall, during the period of organization, be held in trust and, if the organization is not completed within one (1) year as hereinafter provided, returned to said applicants.

The commissioner of insurance may make such examination and require such further information as he deems advisable, and upon presentation of satisfactory evidence that the society has complied with all the provisions of law, he shall issue to such society a certificate to that effect. Such certificate shall be prima facie evidence of the existence of such society at the date of such certificate. The commissioner of insurance shall cause a record of such certificate to be made, and a certified copy of such record may be given in evidence with like effect as the original certificate.

No preliminary certificate granted under the provisions of this section shall be valid after one (1) year from its date, or after such further period, not exceeding one (1) year, as may be authorized by the commissioner of insurance, upon cause shown, unless the five hundred (500) applicants herein required have been secured and the organization has been completed as herein provided. The articles of incorporation and all proceedings thereunder shall become null and void in one (1) year from the date of said preliminary certificate, or at the expiration of said extended period, unless such society shall have completed its organization and commenced business as herein provided. When any domestic society shall have discontinued business for the period of one (1) year, or has less than four hundred (400) members, its charter shall become null and void.

Every such society shall have the power to make a constitution and bylaws for the government of the society, the admission of its members, the management of its affairs, and the fixing and readjusting of the rates of contribution of its members from time to time; and it shall have the power to change, alter, add to, or amend such constitution and bylaws and have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

HISTORY: Codes, 1930, § 5241; 1942, § 5755.

Cross References — Fraternal benefit society defined, see § 83-29-1.

RESEARCH REFERENCES

ALR.

Right of benevolent or fraternal society or organization against use of same or similar name, insignia, or ritual by another organization. 76 A.L.R.2d 1396.

Am. Jur.

36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 8 et seq.

12 Am. Jur. Pl & Pr Forms (Rev), Fraternal Orders and Benefit Societies, Form 81 (complaint, petition, or declaration-for injunction-to enjoin rival organization's use of name, titles, and other paraphernalia).

2B Am. Jur. Legal Forms 2d, Associations and Clubs §§ 27:5 et seq. (formation).

CJS.

10 C.J.S., Beneficial Associations §§ 7 et seq.

§ 83-29-23. Powers retained.

Any society now engaged in transacting business in this state may exercise all of the rights conferred hereby and all of the rights, powers, and privileges now exercised or possessed by it under its charter or articles of incorporation not inconsistent with this chapter, if incorporated. Any such domestic society may, upon filing notice thereof with the commissioner of insurance, be deemed from and after the date of filing such notice to be fully organized under the provisions of this chapter or, if it be a voluntary association, it may incorporate hereunder. No society already organized shall be required to reincorporate hereunder, and any such society may amend its articles of incorporation from time to time in the manner provided therein or in its constitution and laws. All such amendments shall be filed with the commissioner of insurance and shall become operative upon such filing, unless a later time be provided in such amendments or in its articles of incorporation, constitution, or laws.

HISTORY: Codes, 1930, § 5242; 1942, § 5756.

§ 83-29-25. Mergers and transfers.

No domestic society shall merge with or accept the transfer of the membership or funds of any other society unless such merger or transfer is evidenced by a contract in writing, setting out in full the terms and conditions of such merger or transfer and filed with the commissioner of insurance of this state, together with a sworn statement of the financial condition of each of said societies by its president and secretary, or corresponding officers, and a certificate of such officers, duly verified under oath of said officers of each of the contracting societies, that such merger or transfer has been approved by a majority of the votes cast by the members of the supreme legislative or governing body of each of the said societies.

Upon the submission of said contract, financial statements, and certificates, the commissioner of insurance shall examine the same and, if he shall find such financial statements to be correct and the said contract to be in conformity with the provisions of this section and that such merger or transfer is just and equitable to the members of each of said societies, he shall approve said merger or transfer, issue his certificate to that effect, and thereupon the said contract of merger or transfer shall be of full force and effect.

HISTORY: Codes, 1930, § 5243; 1942, § 5757.

RESEARCH REFERENCES

Am. Jur.
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 9.

CJS.
10 C.J.S., Beneficial Associations § 12.

§ 83-29-27. Annual license.

Societies which are now authorized to transact business in this state may continue such business until the first day of January next succeeding the adoption of this chapter, and the authority of such societies may hereafter be renewed annually, but in all cases to terminate on the first day of the succeeding January; provided, however, the license shall continue in full force and effect until the new license is issued or specifically refused. For each such license or renewal the society shall pay the Commissioner of Insurance the fees prescribed in Sections 27-15-83 and 83-5-75.

HISTORY: Codes, 1930, § 5244; 1942, § 5758; Laws, 1978, ch. 441, § 3; Laws, 2002, ch. 327, § 1, eff from and after July 1, 2002.

Cross References — Term of license of insurance company, see § 83-5-71.
Annual license and fees for larger fraternal benefit societies, see § 83-30-53.

§ 83-29-29. Admission of foreign society.

No foreign society not now authorized to transact business in this state shall transact any business herein without a license from the commissioner of insurance. Any such society shall be entitled to transact business within this state upon filing with the commissioner a duly certified copy of its charter or articles of association; a copy of its constitution and laws, certified by its secretary or corresponding officer; a power of attorney to the commissioner as hereinafter provided; the last annual statement of its business, under oath of its president and secretary or corresponding officers, in the form required by the commissioner, duly verified by an examination made by the supervising insurance official of its home state or other state satisfactory to the commissioner of insurance of this state; a certificate from the proper official in its home state, province, or country that the society is legally organized; a copy of its insurance contracts, which must show that benefits are provided for by periodical or other payments by persons holding similar contracts; and upon furnishing the commissioner such other information as he may deem necessary to a proper exhibit of its business and plan of working, and upon showing that its assets are invested in accordance with the laws of the states, territory, district, province, or country where it is organized, he shall issue a license to such society to do business in this state until the first day of the succeeding March. Such license shall, upon compliance with the provisions of this chapter, be renewed annually, but in all cases to terminate on the first day of the succeeding March; provided, however, that license shall continue in full force and effect until the new license be issued or specifically refused. Any foreign society desiring admission to this state shall have the qualifications required of domestic societies organized under this chapter, upon a valuation by any one of the standards authorized in this chapter, and shall at the same time possess net cash assets of not less than One Hundred Thousand Dollars ($100,000.00), or net cash assets of not less than Fifty Thousand Dollars ($50,000.00) with also invested assets of not less than One Hundred Thousand Dollars ($100,000.00), and in each case with additional contingent assets of not less than Three Hundred Thousand Dollars ($300,000.00); and shall have its assets invested as required by the laws of the state, territory, district, country, or province where it is organized. For each such license or renewal the society shall pay the commissioner Twenty-five Dollars ($25.00). When the commissioner refuses to license any society, or revokes its authority to do business in this state, he shall reduce his ruling, order, or decision to writing and file the same in his office, and shall furnish a copy thereof, together with a statement of his reason, to the officers of the society, upon request. Nothing contained in this, or the preceding section, or in this chapter, shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business therein, and such society shall have full right and authority to continue to collect payments from its members, to carry out its contracts, and to perform all the usual functions of said society except that of acquiring and admitting new members in this state after it has either been refused a renewal of its license herein or has voluntarily relinquished said license. Such activities on its part shall not be construed as doing business in said state so as to subject it to any fee, demand, or charge whatsoever from the insurance department or other agency of this state.

HISTORY: Codes, 1930, § 5245; 1942, § 5759; Laws, 1946, ch. 358, § 1.

RESEARCH REFERENCES

Am. Jur.
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 24, 25, 64, 145 to 147.

CJS.
10 C.J.S., Beneficial Associations §§ 5, 18.

§ 83-29-31. Power of attorney and service of process.

Every society, whether domestic or foreign, now transacting business in this state and every such society hereafter applying for admission shall, before being licensed, appoint in writing the Commissioner of Insurance and his successors in office to be its true and lawful attorney on whom all legal process in any action or proceeding against it shall be served, and in such writing shall agree that any lawful process against it which is served upon such attorney shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this state.

Copies of such appointment, certified by the Commissioner of Insurance, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original thereof might be admitted. Service shall only be made upon such attorney, shall be made in duplicate upon the Commissioner of Insurance or, in his absence, upon the person in charge of his office, and shall be deemed sufficient service upon such society. No such service shall be valid or binding against any such society when it is required thereunder to file its answer, pleading, or defense in less than thirty (30) days from the date of mailing the copy of the service to the society. When legal process against any such society is served upon the Commissioner of Insurance, he shall forthwith forward by certified mail one of the duplicate copies prepaid and directed to the secretary or corresponding officer. Legal process shall not be served upon any such society except in the manner provided herein.

HISTORY: Codes, 1930, § 5246; 1942, § 5760; Laws, 2001, ch. 433, § 4, eff from and after July 1, 2001.

Cross References — Notification of foreign company following service of process upon commissioner as its attorney, see § 83-5-11.

Appointment of commissioner as attorney for service of process before sale of insurance stock, see § 83-5-19.

Fee for service of process upon commissioner as attorney, see § 83-5-73.

Appointment of commissioner as attorney for service of process before admission of foreign insurance company, see § 83-21-1.

JUDICIAL DECISIONS

1. In general.

In action on fraternal life policy, defendant could not complain of alleged error in refusing to quash summonses against defendant where defendant appeared and defended action, and hence was not prejudiced by alleged error. Afro-American Sons & Daughters v. Webster, 172 Miss. 602, 161 So. 318, 1935 Miss. LEXIS 185 (Miss. 1935).

Service of process may be had, on foreign trainmen's brotherhood doing insurance business in state without having designated insurance commissioner as agent for process, in same manner as other foreign corporation doing business in state. Brotherhood of Railroad Trainmen v. Agnew, 170 Miss. 604, 155 So. 205, 1934 Miss. LEXIS 155 (Miss. 1934).

Service on officer of local lodge, through whom association dealt, held sufficient. Brotherhood of Railroad Trainmen v. Agnew, 170 Miss. 604, 155 So. 205, 1934 Miss. LEXIS 155 (Miss. 1934).

Brotherhood of Railroad Trainmen, an unincorporated association, held suable in its own name. Varnado v. Whitney, 166 Miss. 663, 147 So. 479, 1933 Miss. LEXIS 371 (Miss. 1933).

§ 83-29-33. Place of meeting.

Any domestic society may provide that the meetings of its legislative or governing body may be held in any state, district, province, or territory wherein such society has subordinate branches, and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state; but its principal office shall be located in this state.

HISTORY: Codes, 1930, § 5247; 1942, § 5761.

RESEARCH REFERENCES

CJS.

10 C.J.S., Beneficial Associations § 29.

§ 83-29-35. No personal liability.

Officers and members of the supreme, grand, or any subordinate body of any such incorporated society shall not be individually liable for the payment of any disability or death benefit provided in the laws and agreements of such society; but the same shall be payable only out of the funds of such society and in the manner provided by its laws.

HISTORY: Codes, 1930, § 5248; 1942, § 5762.

RESEARCH REFERENCES

Am. Jur.
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 30.

6 Am. Jur. Proof of Facts 3d, Civil Liability of Member or Officer of Unincorporated Association, §§ 1 et seq.

§ 83-29-37. Waiver of the provisions of the laws.

The constitution and laws of the society may provide that no subordinate body, nor any of its subordinate officers or members, shall have the power or authority to waive any of the provisions of the laws and constitution of the society, and the same shall be binding on the society and each and every member thereof and on all beneficiaries of members. No custom or course of conduct in violation of any of the provisions of the laws and constitution of the society shall be held to constitute waiver or estoppel on the part of the society.

HISTORY: Codes, 1930, § 5249; 1942, § 5763.

JUDICIAL DECISIONS

1. In general.
Notice of an insured's disability to the local collection agent of a fraternal insurance society was not in compliance with, or a waiver of, the mandate of the society's constitution as to how claims should be propounded and to whom. Columbian Mut. Life Ins. Co. v. Eaves, 185 Miss. 127, 185 So. 557, 1939 Miss. LEXIS 112 (Miss. 1939).

As to change of beneficiary, neither local secretary nor any other officer of local camp had right to waive any provisions in benefit certificate or constitution and laws of society, where constitution withheld such power. Sovereign Camp, W. O. W. v. Valentine, 170 Miss. 707, 155 So. 192, 1934 Miss. LEXIS 151 (Miss. 1934).

RESEARCH REFERENCES

Am. Jur.
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 11-14.

CJS.
10 C.J.S., Beneficial Associations §§ 27, 28.

§ 83-29-39. Benefit not attachable.

No money or other benefit, charity, relief, or aid to be paid, provided, or rendered by any such society shall be liable to attachment, garnishment, or other process, or be seized, taken, appropriated, or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary or any other person who may have a right thereunder, either before or after payment.

HISTORY: Codes, 1930, § 5250; 1942, § 5764.

Cross References — Exemption from seizure under execution or attachment of proceeds of life insurance policy, see §§ 85-3-11 et seq.

§ 83-29-41. Constitution and laws.

Every society transacting business under this chapter shall file with the commissioner of insurance a duly certified copy of all amendments of or additions to its constitution and laws within ninety days (90) after the enactment of the same. Printed copies of the constitution and laws as amended, changed, or added to, certified by the secretary or corresponding officer of the society, shall be prima facie evidence of the legal adoption thereof.

HISTORY: Codes, 1930, § 5251; 1942, § 5765.

RESEARCH REFERENCES

Am. Jur.
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 15 et seq.

CJS.
10 C.J.S., Beneficial Associations § 29.

§ 83-29-43. Annual reports.

(1) Every society transacting business in this state shall annually, on or before the first day of March, file with the commissioner of insurance, in such form as he may require, a statement under oath of its president and secretary, or corresponding officers, of its condition and standing on the thirty-first day of December last preceding and of its transactions for the year ending on that date, and also shall furnish such other information as the commissioner may deem necessary to a proper exhibit of its business and plan of working. The commissioner may at other times require any further statement he may deem necessary to be made relating to such society, for the elucidation of any items in such annual report.

In addition to the annual report herein required, every society shall report annually to the commissioner of insurance on or before the first day of March a valuation by a competent actuary of its certificates in force on the thirty-first day of December last preceding. This valuation shall not be considered or regarded as a test of the financial solvency of the society, but as an indication of the ability of the society to pay the benefits promised under its certificates without change in benefits or in rates of contribution; and each society shall be held to be legally solvent as long as the funds belonging to the society are equal to or in excess of its matured liabilities. For the purposes of this valuation, the society may divide the certificates in its life insurance department into classes or sections according to the rates of contribution charged from time to time.

The method of valuation used shall be such as to produce not less than the net level premium reserves or, if part or the whole of the first year's contributions is used for expenses, the reserve according to the full preliminary term method of valuation or, as to all business hereafter written, the reserve according to the Illinois standard of valuation, the net premiums valued being the net premiums according to the valuation basis used, with due regard to the method used by the society in computing the member's age at entry or at re-rating. If, due to a readjustment or to a change of a member's plan of insurance, the regular rate of contribution paid by the member is lower than the regular rate of contribution he should have paid according to his attained age at the date of readjustment or change of plan of insurance, an additional reserve shall be set up equal to the additional liability caused by the payment of such reduced regular rate of contribution. If a member is paying a regular rate of contribution which is used solely for the payment of benefits, which is in excess of the valuation net premium according to the member's age at entry, or at re-rating, credit may be taken in the valuation for such regular contributions to an amount not greater than the present value of the benefits promised the said member, as at the date of valuation.

The table of mortality used in the valuation shall be the national fraternal congress table of mortality as adopted by the national fraternal congress August 23, 1899, or any other table of mortality recognized by the law of any state as a legal basis for the computation of premiums or reserves for life insurance companies or fraternal societies, or at its option a society may use a table based on its own experience of at least twenty (20) years and covering not less than one hundred thousand (100,000) lives, provided the mortality table used shall reasonably represent the actual mortality experience of the society. The tables used for the valuation of benefits dependent upon total and permanent disability shall be tables based upon reliable experience, and the society may value its life insurance benefits and disability benefits as one contract or may value such benefits separately.

The rate of interest used in the valuation shall not be greater than the average net rate which the society earned on its admitted assets during the five (5) years immediately preceding the date of the valuation.

Any society which shall show by the above method of valuation at four percent (4%) interest per annum or less that the admitted assets belonging to its life insurance department, or any class or section thereof, are at least equal to the reserve determined by the valuation of the certificates of such department, or class or section thereof, together with accrued liabilities under such certificates, may grant to the members in such department, or class or section thereof, any form of withdrawal equities or surrender values, not greater in value in any individual case than the reserve under the certificate, or make loans to them not greater than the value of such withdrawal equities or surrender values, and may make distribution of such portion of the surplus over and above such reserves and accrued liabilities, or may transfer such portion of the said surplus to the assets belonging to any other class or section of the society as may be determined by its board of directors or trustees upon the advice of its actuary.

A report of such valuation and an explanation of the facts concerning the condition of the society, of each class or section, thereby disclosed shall be printed and mailed to each beneficiary member of the society not later than June 1st of each year; or, in lieu thereof, such report of valuation and showing of the society's condition as thereby disclosed may be published in the society's official paper and the issue containing the same mailed to each beneficiary member of the society. The laws of such society shall provide that if the stated periodical contributions of the members are insufficient to pay all matured death and disability claims in full and to provide for the creation and maintenance of the funds required by its laws, additional, increased, or extra rates of contribution shall be collected from the members to meet such deficiency. Such laws may provide that, upon the written application or consent of the member, his certificate may be charged with its proportion of any deficiency disclosed by valuation, with interest not exceeding five percent (5%) per annum.

(2) In lieu of the requirements of subsection (1) of this section, any society now licensed in this state may, prior to ________, file its election, and thereafter, until it shall rescind such action, it may value its certificates on a basis herein designated "accumulation basis" by crediting each member with the net amount contributed for each year and with interest at approximately the net rate earned and by charging him with his share of the losses for each year, herein designated "cost of insurance", and carrying the balance, if any, to his credit. The charge for the cost of insurance may be according to the actual experience of the society applied to a table of mortality recognized by the law of this state, and shall take into consideration the amount at risk during each year, which shall be the amount payable at death less the credit to the member. Except as specifically provided in its articles or laws or contracts, no charge shall be carried forward from the first valuation hereunder against any member for any past share of losses exceeding the contribution and credit. Any excess share of losses chargeable to any member may be paid out of a fund or contributions especially created or required for such purpose. Any member may transfer to any plan adopted by the society with net rates on which tabular reserves are maintained, and on such transfer shall be entitled to make such application of his credit as provided in the laws of the society. Certificates issued, created, or readjusted on a basis providing for adequate rates with adequate reserves to mature such certificates upon assumption for mortality and interest recognized by the law of this state shall be valued on such basis, herein designated the "tabular basis", provided that if on the first valuation under this section a deficiency in reserve shall be shown for any such certificate, the same shall be valued on the accumulation basis. Whenever in any society having members upon the tabular basis and upon the accumulation basis, the total of all costs of insurance provided for any year shall be insufficient to meet the actual death and disability losses for the year, the deficiency shall be met for the year from the available funds after setting aside all credits in the reserve, or from increased contribution, or by an increase in the number of assessments applied to the society as a whole or to classes or members as may be specified in its laws. Savings from a lower amount of death losses may be returned in like manner as may be specified in its laws. If the laws of the society so provide, the assets representing the reserves of any separate class of members may be carried separately for such class as if in an independent society, and the required reserve accumulation of such class so set apart shall not thereafter be mingled with the assets of other classes of the society. A table showing the credits to individual members for each age and

year of entry and showing opposite each credit the tabular reserve required on the whole life, or other plan of insurance specified in the contract, according to assumption for mortality and interest recognized by the law of this state and adopted by the society, shall be filed by the society with each annual report and also be furnished to each member before July 1st of each year. In lieu of the aforesaid statement, there may be furnished to each member within the same time a statement giving the credit for such member and giving the tabular reserve and level rate required for a transfer carrying out the plan of insurance specified in the contract. No table or statement need be made or furnished where the reserves are maintained on the tabular basis. For this purpose, individual bookkeeping accounts for each member shall not be required, and all calculations may be made by actuarial methods. Nothing herein contained shall prevent the maintenance of such surplus over and above the credits on the accumulation basis and the reserves on the tabular basis as the society may provide by or pursuant to its laws; nor to be construed as giving to the individual member any right or claim to any such reserve or credit other than in manner as expressed in the contract and its laws; nor as making any such reserve or credits a liability in determining the legal solvency of the society.

HISTORY: Codes, 1930, § 5252; 1942, § 5766.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance § 96.

§ 83-29-45. Examination of domestic societies.

The Commissioner of Insurance, or any person or persons he may appoint, shall have the power of visitation and examination into the affairs of any domestic society. They shall have free access to all the books, papers, and documents that relate to the business of the society.

The expenses of such examination shall be paid by the society examined, upon statement furnished by the Commissioner of Insurance, and the examination shall be made as often as the commissioner, in his sole discretion, deems appropriate but, at a minimum, at least once in every five (5) years.

Whenever after examination the Commissioner of Insurance is satisfied that any domestic society has failed to comply with any provisions of this chapter, or is exceeding its powers, or is not carrying out its contracts in good faith, or is transacting business fraudulently, or whenever any domestic society, after the existence of one (1) year or more, shall have a membership of less than four hundred (400) or shall determine to discontinue business, the Commissioner of Insurance may present the facts relating thereto to the Attorney General, who shall, if he deem the circumstances warrant, commence an action in quo warranto in a court of competent jurisdiction. Such court shall thereupon notify the officers of such society of a hearing, and if it shall then appear that such society should be closed, said society shall be enjoined from carrying on any further business; and some person shall be appointed receiver of such society and shall proceed at once to take possession of the books, papers, monies, and other assets of the society and shall forthwith, under the direction of the court, proceed to close the affairs of the society and to distribute its funds to those entitled thereto.

HISTORY: Codes, 1930, § 5253; 1942, § 5767; Laws, 2012, ch. 364, § 2, eff from and after July 1, 2012.

RESEARCH REFERENCES

Am. Jur.

36 Am. Jur. 2d, Fraternal Orders and Benefit Societies §§ 143 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 43 (complaint or declaration, in nature of quo warranto, for order appointing receiver for insurance company and enjoining transaction of business).

CJS.

10 C.J.S., Beneficial Associations §§ 15 et seq.

§ 83-29-47. Application for receiver, etc.

No application for injunction against or proceeding for the dissolution of or the appointment of a receiver for any such domestic society or branch thereof shall be entertained by any court in this state unless the same is made by the attorney general or the commissioner of insurance.

HISTORY: Codes, 1930, § 5254; 1942, § 5768; Laws, 1938, ch. 195.

RESEARCH REFERENCES

Am. Jur.

36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 145 to 147.

CJS.

10 C.J.S., Beneficial Associations § 16.

§ 83-29-49. Examination of foreign societies.

The commissioner of insurance, or any person or persons whom he may appoint, may examine any foreign society transacting or applying for admission to transact business in this state. They shall have free access to all the books, papers, and documents that relate to the business of the society. He may, in his discretion, accept in lieu of such examination the latest examination of the insurance department of the state, territory, district, province, or country where such society is organized. The expenses of making any such examination shall be paid by the society upon statement furnished by the commissioner of insurance.

If any such society or its officers refuse to submit to such examination or to comply with the provisions of the section relative thereto, the authority of such society to write new business in this state shall be suspended or license refused until satisfactory evidence is furnished the commissioner relating to the condition and affairs of the society, and during such suspension the society shall not write new business in this state.

HISTORY: Codes, 1930, § 5255; 1942, § 5769.

Cross References — Examination by commissioner of financial condition of foreign insurance company, see § 83-5-79.

§ 83-29-51. No adverse publications.

Pending, during, or after an examination or investigation of such society, either domestic or foreign, the commissioner of insurance shall make public no financial statement, report, or finding, nor shall he permit to become public any financial statement, report, or finding affecting the status, standing, or rights of any such society until a copy thereof shall have been served upon such society, at its home office; nor until such society shall have been afforded a reasonable opportunity to answer any such financial statement, report, or finding and to make such showing in connection therewith as it may desire.

HISTORY: Codes, 1930, § 5256; 1942, § 5770.

§ 83-29-53. Revocation of license.

When the commissioner of insurance on investigation is satisfied that any foreign society transacting business under this chapter has exceeded its powers, or has failed to comply with any provisions of this chapter, or is conducting business fraudulently, or is not carrying out its contracts in good faith, he shall notify the society of his findings and state in writing the grounds of his dissatisfaction, and after reasonable notice require said society, on a date named, to show cause why its license should not be revoked. If on the date named in said notice such objections have not been removed to the satisfaction of the said commissioner or the society does not present good and sufficient reasons why its authority to transact business in this state should not at that time be revoked, he may revoke the authority of the society to continue business in this state. All decisions and findings of the commissioner made under the provisions of this section may be reviewed by proper proceedings in any court of competent jurisdiction.

HISTORY: Codes, 1930, § 5257; 1942, § 5771.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance § 124.

§ 83-29-55. Certain societies not affected.

Nothing contained in this chapter shall be construed to affect or apply to grand or subordinate lodges of Masons, Odd Fellows, or Knights of Pythias exclusive of the insurance department of the supreme lodge Knights of Pythias, and the Junior Order of United American Mechanics exclusive of beneficiary degree or insurance branch of the National Council Junior Order United American Mechanics, or societies which admit to membership only persons engaged in one or more hazardous occupation in the same or similar lines of business. The commissioner of insurance may require from any society such information as will enable him to determine whether such society is exempt from the provisions of this chapter.

Any fraternal benefit society heretofore organized and incorporated and operating within the definition set forth in Sections 83-29-1, 83-29-3, and 83-29-5, providing for benefits in case of death or disability resulting solely from accidents, but which does not obligate itself to pay death or sick benefits, may be licensed under the provisions of this chapter, and shall have all the privileges and shall be subject to all the provisions and regulations of this chapter, except that the provisions of this chapter as to valuations of benefit certificates shall not apply to such society.

HISTORY: Codes, 1930, § 5258; 1942, § 5772; Laws, 1938, ch. 192.

§ 83-29-57. Taxation.

Every fraternal benefit society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution; and all of its funds shall be exempt from all and every state, county, district, municipal and state tax other than insurance license taxes as defined by Section 27-15-83 and ad valorem taxes on real estate, office equipment and motor vehicles.

HISTORY: Codes, 1930, § 5259; 1942, § 5773; Laws, 1978, ch. 441, § 7, eff from and after July 1, 1978.

Cross References — Homestead exemption for property of a fraternal or benevolent organization, see §§ 27-33-17, 27-33-19.

Exemption of larger fraternal benefit society funds from taxation, see § 83-30-47.

RESEARCH REFERENCES

Am. Jur.

71 Am. Jur. 2d, State and Local Taxation §§ 330, 331.

CJS.

84 C.J.S., Taxation §§ 300, 301.

§ 83-29-59. Penalties.

Any person, officer, member, or examining physician of any society authorized to do business under this chapter who shall knowingly or wilfully make any false or fraudulent statement or representation in or with reference to any application for membership, or for the purpose of obtaining money from or benefit in any society transacting business under this chapter, shall be guilty of a misdemeanor and, upon conviction thereof, shall be punished by a fine of not less than One Hundred Dollars ($100.00) nor more than Five

Hundred Dollars ($500.00), or imprisonment in the county jail for not less than thirty (30) days nor more than one (1) year, or both, in the discretion of the court. Any person who shall willfully make a false statement of any material fact or thing in a sworn statement as to the death or disability of a certificate holder in any such society for the purpose of procuring payment of a benefit named in the certificate of such holder, and any person who shall willfully make any false statement in any verified report or declaration under oath required or authorized by this chapter, shall be guilty of perjury and shall be proceeded against and punished as provided by the statutes of this state in relation to the crime of perjury.

Any person who shall solicit membership for, or in any manner assist or procure membership in, any fraternal benefit society not licensed to do business in this state, or who shall solicit membership for, or in any manner assist in procuring membership in, any such society not authorized as herein provided to do business as herein defined in this state, shall be punished by a fine of not less than Fifty Dollars ($50.00) nor more than Two Hundred Dollars ($200.00).

Any society, or any officer, agent, or employee thereof neglecting or refusing to comply with, or violating any of the provisions of this chapter, the penalty for which neglect, refusal, or violation is not specified in this section, shall be fined not exceeding Two Hundred Dollars ($200.00) upon conviction thereof.

HISTORY: Codes, 1930, § 5260; 1942, § 5774.

Cross References — Perjury, see §§ 97-9-59 through 97-9-65.
Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 69.

CJS.
44 C.J.S., Insurance § 139.

§ 83-29-61. Fraternal benefit societies must give bond.

All fraternal benefit societies domiciled in or incorporated under the laws of Mississippi, or whose principal place of business is therein, shall be required to give a bond in some surety company licensed in Mississippi or in approved securities consisting of bonds of some municipality, county, levee board, or of the State of Mississippi. The minimum of said bond or securities shall be Two Hundred and Fifty Dollars ($250.00) for a minimum membership of two hundred (200), and to increase in sums of Two Hundred and Fifty Dollars ($250.00) for each two hundred (200) additional members, or fraction thereof, until it amounts to the maximum sum of Ten Thousand Dollars ($10,000.00).

HISTORY: Codes, Hemingway's 1917, § 5206; 1930, § 5261; 1942, § 5775; Laws, 1916, ch. 204.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 72.

CJS.
44 C.J.S., Insurance § 39.

§ 83-29-63. Suit and judgment on bond.

Said bond shall be conditioned to pay any judgment entered up against any such society in any court of competent jurisdiction in this state, and such judgment shall be a lien upon the bond or securities. The judgment creditor shall have the right to bring suit on said bond for the satisfaction of the judgment in the county in which the judgment is rendered. If the present bylaws of such societies provide for the payment of beneficiaries the sum received from one (1) monthly assessment, nothing herein shall amend or annul the terms of such policies, provided that all beneficiaries shall be paid within ninety (90) days after proof of death has been filed with the proper officer of the society, that said assessments shall be made each month to cover the deaths occurring during the preceding months, and that the funds secured from such monthly assessments shall be kept separately and the total amount of each monthly assessment shall be clearly shown on the book account, together with the names of the beneficiaries and the amount due them; provided, that societies may levy extra assessments to pay claims already due.

One or more suits on the bond herein required shall not vitiate the bond or prevent additional recovery thereon; but when judgments shall be recovered to the amount of the bond, the insurance commissioner shall require an additional bond.

HISTORY: Codes, Hemingway's 1917, § 5207; 1930, § 5262; 1942, § 5776; Laws, 1916, ch. 204.

Cross References — Definition of insurance contract, see § 83-5-5.
Revocation of license of insurance company for unsatisfied judgment, see § 83-5-21.

JUDICIAL DECISIONS

1. In general.
Brotherhood of Railroad Trainmen, an unincorporated association, is suable in its own name. Varnado v. Whitney, 166 Miss. 663, 147 So. 479, 1933 Miss. LEXIS 371 (Miss. 1933).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

CJS.
44 C.J.S., Insurance §§ 105-115, 129, 130.

§ 83-29-65. Society must make up all delinquencies.

Domestic societies delinquent with their beneficiaries for death claims must show an improvement by annually decreasing the amount of same not less than five percent (5%). Failure to do so shall subject them to a revocation of their license.

HISTORY: Codes, Hemingway's 1917, § 5208; 1930, § 5263; 1942, § 5777; Laws, 1916, ch. 204.

RESEARCH REFERENCES

ALR.

Insurer's liability for consequential or punitive damages for wrongful delay or refusal to make payments due under contracts. 47 A.L.R.3d 314.

Am. Jur.

43 Am. Jur. 2d, Insurance § 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance § 124.

§ 83-29-67. Separate expense fund must be provided.

All fraternal societies incorporated under the laws of this state, or operating herein, or whose principal place of business is in this state, shall provide a separate fund from which to pay expenses, which shall not exceed for established societies more than twenty percent (20%) of total collections, nor more than twenty-five percent (25%) during the period of organization. Where practicable, the mortality funds shall be kept separate from other funds and be used only for the purpose of paying death benefits.

HISTORY: Codes, Hemingway's 1917, § 5209; 1930, § 5264; 1942, § 5778; Laws, 1916, ch. 204; Laws, 1940, ch. 207.

RESEARCH REFERENCES

Am. Jur.

36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 23.

CJS.

10 C.J.S., Beneficial Associations § 32.

§ 83-29-69. Authority of fraternal orders revoked for failure to pay judgments.

If a judgment shall be rendered by any court in this state against any fraternal order and such judgment shall not be paid and satisfied within ninety (90) days after the same shall have become final, it shall be the imperative duty of the insurance commissioner, immediately upon being advised that such judgment has not been paid or satisfied within the time named, to revoke any and every authority granted to such fraternal order, or any agent thereof, to transact any business in this state. No such fraternal order, or agent thereof, shall thereafter transact any business in this state until again duly licensed, and in case of such revocation no renewal license or certificate of authority to transact business in this state shall be granted to such fraternal order for three (3) years after such revocation. Whenever such license or certificate of authority shall be revoked, the insurance commissioner shall publish such revocation in some newspaper published in this state.

HISTORY: Codes, Hemingway's 1917, § 5210; 1930, § 5265; 1942, § 5779; Laws, 1912, ch. 173.

Cross References — Revocation of license of insurance company for unsatisfied judgment, see § 83-5-21.

Revocation of authority of domestic insurance company to transact new business on ground of impairment of capital, see § 83-19-57.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance § 124.

§ 83-29-71. Conversion of fraternal benefit societies into stock companies.

Any fraternal benefit society organized and doing business under the laws of this state may be converted into a stock life or stock life and disability company upon the terms and conditions as follows:

Whenever the supreme governing legislative body of any fraternal benefit society incorporated under the laws of this state shall, by a two-thirds (⅔) vote, determine that a change or conversion from a fraternal benefit society to a regular stock life or stock life and disability company shall be to the best interest of the society and its members, or when a majority of the members in good standing of any such domestic fraternal benefit society shall in writing signify their desire for such conversion, or in event the supreme governing legislative body of any fraternal benefit society prior to the adoption of this chapter has by proper resolution expressed its desire and purpose to change or convert said society into a level premium life insurance company, then in either event said fraternal benefit society may adopt and file with the insurance commissioner of Mississippi an amendment or amendments to its articles of incorporation authorizing it to change or convert from a fraternal to a domestic stock life or stock life and disability company; and said amendment shall become operative upon its approval by the insurance commissioner unless a later time be provided in said amendment. If the amendment is approved by the insurance commissioner, he shall issue his certificate of approval in writing. Thereafter the company shall have legal existence as a domestic stock life or stock life and disability company as indicated by the amendment, may reorganize by the election of a board of directors and the adoption of bylaws, and proceed to transact the business of such company in accordance with and be subject to all laws defining the powers and providing for the regulation of stock life insurance companies.

Provided, however, that no such conversion from a fraternal benefit society to a regular stock or disability company shall be had unless written notice of such proposed change be deposited in the United States mail, registered and postage prepaid, to every member of such fraternal benefit society at his last known post office address at least ninety (90) days before the proposed change or conversion is to be acted upon by the supreme governing body; but the notice provided herein shall not apply to or be required of any fraternal society whose district councils, or state or division grand lodges composed of delegates from branch councils or subordinate lodges, have by a two-thirds (⅔) vote already authorized or instructed its national council or supreme legislative governing body to change or convert their society into a level premium life insurance or disability company before March 19, 1926, or when such proposed change to a stock life or stock life and disability company, before becoming effective, is submitted to and unanimously approved by the national council or supreme governing body of such fraternal society at a regular meeting of such national council or supreme governing body, or at a special meeting of the national council or supreme governing body called by the national or supreme president for the purpose of considering such proposal. The national or supreme president of any such fraternal benefit society may prepare in writing a ballot and, on ninety (90) days' written notice to each member, take a referendum vote in writing as to any such proposed change or conversion. If two thirds (⅔) of the membership by said referendum vote authorize the national council or supreme legislative governing body to change or convert the society into a stock life or stock life and disability company, then in that event the national council or supreme legislative governing body of said society may proceed to vote said change, and its action in the premises shall be binding upon all members. The amendment to the charter, the method of placing any surplus belonging to any such fraternal benefit society to capital stock, and the method of prorating the stock among the membership in a way to protect the interests of all policyholders and members, shall be under the jurisdiction of the insurance commissioner and subject to his approval.

HISTORY: Codes, 1930, § 5266; 1942, § 5780; Laws, 1926, ch. 260.

Cross References — Conversion of larger fraternal benefit society into mutual or stock insurer, see § 83-30-29.

Conversion of fraternal society into mutual life and disability insurance company, see § 83-31-15.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 15.	10 C.J.S., Beneficial Associations § 9.

§ 83-29-73. Fraternal societies may insure children.

Any fraternal benefit society organized under the laws of this state, or doing business in this state, may issue certificates for the payment of sick, death, or annuity benefits upon the lives of children between the ages of one (1) and eighteen (18) years who have been examined and approved in accordance with the laws of such society, provided that the applications for such a benefit certificate shall be made by a parent or guardian of such child or some person upon whom the child is dependent for support. When such child shall arrive at the age permitting a personal application for insurance under the laws of the society, the certificate issued under this provision may be exchanged for any other form of certificate issued by the society, such exchange to be in accordance with the constitution, laws, and regulations of such society, the free designation of a beneficiary in such exchange being left to the child.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209el; 1930, § 5267; 1942, § 5781; Laws, 1918, ch. 212.

Cross References — Authority for minors to contract for insurance, see § 83-7-19.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 49.	10 C.J.S., Beneficial Associations § 41.

§ 83-29-75. Conditions under which certificates to be issued.

Such society shall not issue any such benefit certificate until after it shall have simultaneously put in force at least five hundred (500) such certificates, on each of which at least one (1) assessment has been paid, nor where the number of lives represented by such certificate falls below five hundred (500).

HISTORY: Codes, Hemingway's 1921 Supp. § 5209fl; 1930, § 5268; 1942, § 5782; Laws, 1918, ch. 212.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
36 Am. Jur. 2d, Fraternal Orders and Benefit Societies § 22.	10 C.J.S., Beneficial Associations § 30.

CHAPTER 30.

LARGER FRATERNAL BENEFIT SOCIETIES

Article 1. Structure and Purpose. 83-30-1
Article 3. Membership. 83-30-11
Article 5. Governance. 83-30-19
Article 7. Contractual Benefits. 83-30-31
Article 9. Financial. 83-30-41
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Article 13. Miscellaneous Provisions. 83-30-69

ARTICLE 1.

STRUCTURE AND PURPOSE.

Sec.
83-30-1. Larger fraternal benefit societies.
83-30-3. Lodge system.
83-30-5. Representative form of government.
83-30-7. Terms used.
83-30-9. Purposes and powers.

§ 83-30-1. Larger fraternal benefit societies.

Any incorporated society, order or supreme lodge, without capital stock, including one exempted under the provisions of Section 83-30-73(1) whether incorporated or not, conducted solely for the benefit of its members and their beneficiaries and not for profit, operated on a lodge system with ritualistic form of work, having more than Thirty Thousand Dollars ($30,000.00) in total annual written premium, having a representative form of government, and which provides benefits in accordance with this chapter, is hereby declared to be a larger fraternal benefit society.

HISTORY: Laws, 2001, ch. 362, § 1, eff from and after July 1, 2001.

Cross References — Fraternal benefit societies, see §§ 83-29-1 et seq.

§ 83-30-3. Lodge system.

(1) A society is operating on the lodge system if it has a supreme governing body and subordinate lodges into which members are elected, initiated or admitted in accordance with its laws, rules and ritual. Subordinate lodges shall be required by the laws of the society to hold regular meetings at least once in each month in furtherance of the purposes of the society.

(2) A society may, at its option, organize and operate lodges for children under the minimum age for adult membership. Membership and initiation in local lodges shall not be required of such children, nor shall they have a voice or vote in the management of the society.

HISTORY: Laws, 2001, ch. 362, § 2, eff from and after July 1, 2001.

Cross References — Definition of lodge system as it applies to fraternal benefit societies, see § 83-29-3.

§ 83-30-5. Representative form of government.

A society has a representative form of government when:

(a) It has a supreme governing body constituted in one of the following ways:

(i) Assembly. The supreme governing body is an assembly composed of delegates elected directly by the members or at intermediate assemblies or conventions of members or their representatives, together with other delegates as may be prescribed in the society's laws. A society may provide for election of delegates by mail. The elected delegates shall constitute a majority in number and shall not have less than two-thirds (⅔) of the votes and not less than the number of votes required to amend the society's laws. The assembly shall be elected and shall meet at least once every four (4) years and shall elect a board of directors to conduct the business of the society between meetings of the assembly. Vacancies on the board of directors between elections may be filled in the manner prescribed by the society's laws.

(ii) Direct Election. The supreme governing body is a board composed of persons elected by the members, either directly or by their representatives in intermediate assemblies, and any other persons prescribed in the society's laws. A society may provide for election of the board by mail. Each term of a board member may not exceed four (4) years. Vacancies on the board between elections may be filled in the manner prescribed by the society's laws. Those persons elected to the board shall constitute a majority in number and not less than the number of votes required to amend the society's laws. A person filling the unexpired term of an elected board member shall be considered to be an elected member. The board shall meet at least quarterly to conduct the business of the society.

(b) The officers of the society are elected either by the supreme governing body or by the board of directors;

(c) Only benefit members are eligible for election to the supreme governing body and the board of directors; and

(d) Each voting member shall have one (1) vote; no vote may be cast by proxy.

HISTORY: Laws, 2001, ch. 362, § 3, eff from and after July 1, 2001.

Cross References — Definition of representative form of government as it applies to fraternal benefit societies, see § 83-29-5.

§ 83-30-7. Terms used.

Whenever used in this chapter:

(a) "Benefit contract" shall mean the agreement for provision of benefits authorized by Section 83-30-31, as that agreement is described in Section 83-30-37(1).

(b) "Benefit member" shall mean an adult member who is designated by the laws or rules of the society to be a benefit member under a benefit contract.

(c) "Certificate" shall mean the document issued as written evidence of the benefit contract.

(d) "Commissioner" shall mean the Commissioner of Insurance of this state.

(e) "Laws" shall mean the society's articles of incorporation, constitution and bylaws, however designated.

(f) "Lodge" shall mean subordinate member units of the society, known as camps, courts, councils, branches or by any other designation.

(g) "Premiums" shall mean premiums, rates, dues or other required contributions by whatever name known, which are payable under the certificate.

(h) "Rules" shall mean all rules, regulations or resolutions adopted by the supreme governing body or board of directors which are intended to have general application to the members of the society.

(i) "Society" shall mean larger fraternal benefit society as defined in Section 83-30-1, unless otherwise indicated.

HISTORY: Laws, 2001, ch. 362, § 4, eff from and after July 1, 2001.

§ 83-30-9. Purposes and powers.

(1) A society shall operate for the benefit of members and their beneficiaries by:

(a) Providing benefits as specified in Section 83-30-31; and

(b) Operating for one or more social, intellectual, educational, charitable, benevolent, moral, fraternal, patriotic or religious purposes for the benefit of its members, which may also be extended to others.

Such purposes may be carried out directly by the society, or indirectly through subsidiary corporations or affiliated organizations.

(2) Every society shall have the power to adopt laws and rules for the government of the society, the admission of its members, and the management of its affairs. It shall have the power to change, alter, add to or amend such laws and rules and shall have such other powers as are necessary and incidental to carrying into effect the objects and purposes of the society.

HISTORY: Laws, 2001, ch. 362, § 5, eff from and after July 1, 2001.

ARTICLE 3.

MEMBERSHIP.

Sec.
83-30-11. Qualifications for membership.
83-30-13. Location of office, meetings, communications to members, grievance procedures.

Sec.
83-30-15. No personal liability.
83-30-17. Waiver.

§ 83-30-11. Qualifications for membership.

(1) A society shall specify in its laws or rules:

(a) Eligibility standards for each and every class of membership, provided that if benefits are provided on the lives of children, the minimum age for adult membership shall be set at not less than age fifteen (15) and not greater than age twenty-one (21);

(b) The process for admission to membership for each membership class; and

(c) The rights and privileges of each membership class, provided that only benefit members shall have the right to vote on the management of the insurance affairs of the society.

(2) A society may also admit social members who shall have no voice or vote in the management of the insurance affairs of the society.

(3) Membership rights in the society are personal to the member and are not assignable.

HISTORY: Laws, 2001, ch. 362, § 6, eff from and after July 1, 2001.

§ 83-30-13. Location of office, meetings, communications to members, grievance procedures.

(1) The principal office of any domestic society shall be located in this state. The meetings of its supreme governing body may be held in any state, district, province or territory wherein such society has at least one (1) subordinate lodge, or in such other location as determined by the supreme governing body, and all business transacted at such meetings shall be as valid in all respects as if such meetings were held in this state. The minutes of the proceedings of the supreme governing body and of the board of directors shall be in the English language.

(2)(a) A society may provide in its laws for an official publication in which any notice, report, or statement required by law to be given to members, including notice of election, may be published. Such required reports, notices and statements shall be printed conspicuously in the publication. If the records of a society show that two (2) or more members have the same mailing address, an official publication mailed to one (1) member is deemed to be mailed to all members at the same address unless a member requests a separate copy.

(b) Not later than June 1 of each year, a synopsis of the society's annual statement providing an explanation of the facts concerning the condition of the society thereby disclosed shall be printed and mailed to each benefit member of the society or, in lieu thereof, such synopsis may be published in the society's official publication.

(3) A society may provide in its laws or rules for grievance or complaint procedures for members.

HISTORY: Laws, 2001, ch. 362, § 7, eff from and after July 1, 2001.

§ 83-30-15. No personal liability.

(1) The officers and members of the supreme governing body or any subordinate body of a society shall not be personally liable for any benefits provided by a society.

(2) Any person may be indemnified and reimbursed by any society for expenses reasonably incurred by, and liabilities imposed upon, such person in connection with or arising out of any action, suit or proceeding, whether civil, criminal, administrative or investigative, or threat thereof, in which the person may be involved by reason of the fact that he or she is or was a director, officer, employee or agent of the society or of any firm, corporation or organization which he or she served in any capacity at the request of the society. A person shall not be so indemnified or reimbursed (a) in relation to any matter in such action, suit or proceeding as to which he or she shall finally be adjudged to be or have been guilty of breach of a duty as a director, officer, employee or agent of the society, or (b) in relation to any matter in such action, suit or proceeding, or threat thereof, which has been made the subject of a compromise settlement; unless in either such case the person acted in good faith for a purpose the person reasonably believed to be in or not opposed to the best interests of the society and, in a criminal action or proceeding, in addition, had no reasonable cause to believe that his or her conduct was unlawful. The determination whether the conduct of such person met the standard required in order to justify indemnification and reimbursement in relation to any matter described in subsection (1) or (2) may only be made by the supreme governing body or board of directors by a majority vote of a quorum consisting of persons who were not parties to such action, suit or proceeding or by a court of competent jurisdiction. The termination of any action, suit or proceeding by judgment, order, settlement, conviction, or upon a plea of no contest, as to such person shall not in itself create a conclusive presumption that the person did not meet the standard of conduct required in order to justify indemnification and reimbursement. The foregoing right of indemnification and reimbursement shall not be exclusive of other rights to which such person may be entitled as a matter of law and shall inure to the benefit of his or her heirs, executors and administrators.

(3) A society shall have power to purchase and maintain insurance on behalf of any person who is or was a director, officer, employee or agent of the society, or who is or was serving at the request of the society as a director, officer, employee or agent of any other firm, corporation, or organization against any liability asserted against such person and incurred by him or her in any such capacity or arising out of his or her status as such, whether or not the society would have the power to indemnify the person against such liability under this section.

(4) No director, officer, employee, member or volunteer of a society serving without compensation, shall be liable, and no cause of action may be brought, for damages resulting from the exercise of judgment or discretion in connection with the duties or responsibilities of such person for the society unless such act or omission involved willful or wanton misconduct.

HISTORY: Laws, 2001, ch. 362, § 8, eff from and after July 1, 2001.

§ 83-30-17. Waiver.

The laws of the society may provide that no subordinate body, nor any of its subordinate officers or members shall have the power or authority to waive any of the provisions of the laws of the society. Such provision shall be binding on the society and every member and beneficiary of a member.

HISTORY: Laws, 2001, ch. 362, § 9, eff from and after July 1, 2001.

ARTICLE 5.

GOVERNANCE.

Sec.
83-30-19. Organization.
83-30-21. Amendments to laws.
83-30-23. Institutions.
83-30-25. Reinsurance.
83-30-27. Consolidations and mergers.
83-30-29. Conversion of fraternal benefit society into a mutual or stock insurer.

§ 83-30-19. Organization.

A domestic society organized on or after July 1, 2001, shall be formed as follows:

(a) Seven (7) or more citizens of the United States, a majority of whom are citizens of this state, who desire to form a fraternal benefit society, may make, sign and acknowledge before some officer competent to take acknowledgment of deeds, articles of incorporation, in which shall be stated:

(i) The proposed corporate name of the society, which shall not so closely resemble the name of any society or insurance company as to be misleading or confusing;

(ii) The purposes for which it is being formed and the mode in which its corporate powers are to be exercised. Such purposes shall not include more liberal powers than are granted by this chapter;

(iii) The names and residences of the incorporators and the names, residences and official titles of all the officers, trustees, directors, or other persons who are to have and exercise the general control of the management of the affairs and funds of the society for the first year or until the ensuing election at which all such officers shall be elected by the supreme governing body, which election shall be held not later than one (1) year from the date of issuance of the permanent certificate of authority.

(b) Such articles of incorporation, duly certified copies of the society's bylaws and rules, copies of all proposed forms of certificates, applications therefor, and circulars to be issued by the society and a bond conditioned upon the return to applicants of the advanced payments if the organization is not completed within one (1) year shall be filed with the commissioner, who may require such further information as the commissioner deems necessary. The bond with sureties approved by the commissioner shall be in such amount, not less than Three Hundred Thousand Dollars ($300,000.00), nor more than One Million Five Hundred Thousand Dollars ($1,500,000.00), as required by the commissioner. All documents filed are to be in the English language. If the purposes of the society conform to the requirements of this chapter and all provisions of the law have been complied with, the commissioner shall so certify, retain and file the articles of incorporation and shall furnish the incorporators a preliminary certificate of authority authorizing the society to solicit members as hereinafter provided.

(c) No preliminary certificate of authority granted under the provisions of this section shall be valid after one (1) year from its date or after such further period, not exceeding one (1) year, as may be authorized by the commissioner upon cause shown, unless the five hundred (500) applicants hereinafter required have been secured and the organization has been completed as herein provided. The charter and all other proceedings thereunder shall become null and void in one (1) year from the date of the preliminary certificate of authority, or at the expiration of the extended period, unless the society shall have completed its organization and received a certificate of authority to do business as hereinafter provided.

(d) Upon receipt of a preliminary certificate of authority from the commissioner, the society may solicit members for the purpose of completing its organization, shall collect from each applicant the amount of not less than one (1) regular monthly premium in accordance with its table of rates, and shall issue to each such applicant a receipt for the amount so collected. No society shall incur any liability other than for the return of such advance premium, nor issue any certificate, nor pay, allow, or offer or promise to pay or allow, any benefit to any person until:

(i) Actual bona fide applications for benefits have been secured on not less than five hundred (500) applicants, and any necessary evidence of insurability has been furnished to and approved by the society;

(ii) At least ten (10) subordinate lodges have been established into which the five hundred (500) applicants have been admitted;

(iii) There has been submitted to the commissioner, under oath of the president or secretary, or corresponding officer of the society, a list of such applicants, giving their names, addresses, date each was admitted, name and number of the subordinate lodge of which each applicant is a member, amount of benefits to be granted and premiums therefor; and

(iv) It shall have been shown to the commissioner, by sworn statement of the treasurer, or corresponding officer of such society, that at least five hundred (500) applicants have each paid in cash at least one (1) regular monthly premium as herein provided, which premiums in the aggregate shall amount to at least One Hundred Fifty Thousand Dollars ($150,000.00). Said advance premiums shall be held in trust during the period of organization and if the society has not qualified for a certificate of authority within one (1) year, as herein provided, such premiums shall be returned to said applicants.

(e) The commissioner may make such examination and require such further information as the commissioner deems advisable. Upon presentation of satisfactory evidence that the society has complied with all the provisions of law, the commissioner shall issue to the society a certificate of authority to that effect and that the society is authorized to transact business pursuant to the provisions of this chapter. The certificate of authority shall be prima facie evidence of the existence of the society at the date of such certificate. The commissioner shall cause a record of such certificate of authority to be made. A certified copy of such record may be given in evidence with like effect as the original certificate of authority.

(f) Any incorporated society authorized to transact business in this state on July 1, 2001, shall not be required to reincorporate.

HISTORY: Laws, 2001, ch. 362, § 10, eff from and after July 1, 2001.

§ 83-30-21. Amendments to laws.

(1) A domestic society may amend its laws in accordance with the provisions thereof by action of its supreme governing body at any regular or special meeting thereof or, if its laws so provide, by referendum. Such referendum may be held in accordance with the provisions of its laws by the vote of the voting members of the society, by the vote of delegates or representatives of voting members or by the vote of local lodges. A society may provide for voting by mail. No amendment submitted for adoption by referendum shall be adopted unless, within six (6) months from the date of submission thereof, a majority of the members voting shall have signified their consent to such amendment by one (1) of the methods herein specified.

(2) No amendment to the laws of any domestic society shall take effect unless approved by the commissioner who shall approve such amendment if the commissioner finds that it has been duly adopted and is not inconsistent with any requirement of the laws of this state or with the character, objects and purposes of the society. Unless the commissioner shall disapprove any such amendment within sixty (60) days after the filing of same, such amendment shall be considered approved. The approval or disapproval of the commissioner shall be forwarded in writing, and mailed to the secretary or corresponding officer of the society at its principal office. In case the commissioner disapproves such amendment, the reasons therefor shall be stated in such written notice.

(3) Within ninety (90) days from the approval thereof by the commissioner, all such amendments, or a synopsis thereof, shall be furnished to all

members of the society either by mail or by publication in full in the official publication of the society. The affidavit of any officer of the society or of anyone authorized by it to mail any amendments or synopsis thereof, stating facts which show that same have been duly addressed and mailed, shall be prima facie evidence that such amendments or synopsis thereof, have been furnished the addressee.

(4) Every foreign or alien society authorized to do business in this state shall file with the commissioner a duly certified copy of all amendments of, or additions to, its laws within ninety (90) days after the enactment of same.

(5) Printed copies of the laws as amended, certified by the secretary or corresponding officer of the society shall be prima facie evidence of the legal adoption thereof.

HISTORY: Laws, 2001, ch. 362, § 11, eff from and after July 1, 2001.

§ 83-30-23. Institutions.

A society may create, maintain and operate, or may establish organizations to operate, not for profit institutions to further the purposes permitted by Section 83-30-9(1)(b). Such institutions may furnish services free or at a reasonable charge. Any real or personal property owned, held or leased by the society for this purpose shall be reported in every annual statement but shall not be allowed as an admitted asset of such society.

HISTORY: Laws, 2001, ch. 362, § 12, eff from and after July 1, 2001.

§ 83-30-25. Reinsurance.

(1) A domestic society may, by a reinsurance agreement, cede any individual risk or risks in whole or in part to an insurer (other than another fraternal benefit society) having the power to make such reinsurance and authorized to do business in this state, or if not so authorized, one which is approved by the commissioner but no such society may reinsure substantially all of its insurance in force without the written permission of the commissioner. It may take credit for the reserves on such ceded risks to the extent reinsured, but no credit shall be allowed as an admitted asset or as a deduction from liability, to a ceding society for reinsurance made, ceded, renewed, or otherwise becoming effective after July 1, 2001, unless the reinsurance is payable by the assuming insurer on the basis of the liability of the ceding society under the contract or contracts reinsured without diminution because of the insolvency of the ceding society.

(2) Notwithstanding subsection (1) of this section, a society may reinsure the risks of another society in a consolidation, merger or assumption reinsurance transaction approved by the commissioner.

HISTORY: Laws, 2001, ch. 362, § 13, eff from and after July 1, 2001.

§ 83-30-27. Consolidations and mergers.

(1) A domestic society may consolidate or merge with any other society by

complying with the provisions of this section. It shall file with the commissioner:

(a) A certified copy of the written contract containing in full the terms and conditions of the consolidation or merger;

(b) A sworn statement by the president and secretary or corresponding officers of each society showing the financial condition thereof on a date fixed by the commissioner, but not earlier than December 31 next preceding the date of the contract;

(c) A certificate of such officers, duly verified by their respective oaths, that the consolidation or merger has been approved by a two-thirds (⅔) vote of the supreme governing body of each society, such vote being conducted at a regular or special meeting of each such body, or, if the society's laws so permit, by mail; and

(d) Evidence that at least sixty (60) days prior to the action of the supreme governing body of each society, the text of the contract has been furnished to all members of each society either by mail or by publication in full in the official publication of each society.

(2) If the commissioner finds that the contract is in conformity with the provisions of this section, that the financial statements are correct, and that the consolidation or merger is just and equitable to the members of each society, the commissioner shall approve the contract and issue a certificate to such effect. Upon such approval, the contract shall be in full force and effect unless any society which is a party to the contract is incorporated under the laws of any other state or territory. In such event the consolidation or merger shall not become effective unless and until it has been approved as provided by the laws of such state or territory and a certificate of such approval filed with the commissioner, or, if the laws of such state or territory contain no such provision, then the consolidation or merger shall not become effective unless and until it has been approved by the Commissioner of Insurance of such state or territory and a certificate of such approval filed with the commissioner.

(3) Upon the consolidation or merger becoming effective as herein provided, all the rights, franchises and interests of the consolidated or merged societies in and to every species of property, real, personal or mixed, and things in action thereunto belonging shall be vested in the society resulting from or remaining after the consolidation or merger without any other instrument, except that conveyances of real property may be evidenced by proper deeds, and the title to any real estate or interest therein, vested under the laws of this state in any of the societies consolidated or merged, shall not revert or be in any way impaired by reason of the consolidation or merger, but shall vest absolutely in the society resulting from or remaining after such consolidation or merger.

(4) The affidavit of any officer of the society or of anyone authorized by it to mail any notice or document, stating that such notice or document has been duly addressed and mailed, shall be prima facie evidence that such notice or document has been furnished the addressees.

HISTORY: Laws, 2001, ch. 362, § 14, eff from and after July 1, 2001.

§ 83-30-29. Conversion of fraternal benefit society into a mutual or stock insurer.

(1) Any domestic fraternal benefit society organized and doing business under the laws of this state may be converted and licensed as a mutual life or mutual life and disability insurance company by compliance with all the requirements of Section 83-31-15.

(2) Any fraternal benefit society organized and doing business under the laws of this state may be converted into a stock like or stock life and disability company upon the terms and conditions as follows:

(a) Whenever the supreme governing legislative body of any fraternal benefit society incorporated under the laws of this state shall, by a two-thirds (⅔) vote, determine that a change or conversion from a fraternal benefit society to a regular stock life or stock life and disability company shall be to the best interest of the society and its members, or when a majority of the members in good standing of any such domestic fraternal benefit society shall in writing signify their desire for such conversion, or in event the supreme governing legislative body of any fraternal benefit society prior to the adoption of this chapter has by proper resolution expressed its desire and purpose to change or convert said society into a level premium life insurance company, then in either event said fraternal benefit society may adopt and file with the commissioner an amendment or amendments to its articles of incorporation authorizing it to change or convert from a fraternal to a domestic stock life or stock life and disability company; and said amendment shall become operative upon its approval by the commissioner unless a later time be provided in said amendment. If the amendment is approved by the commissioner, he or she shall issue a certificate of approval in writing. Thereafter the company shall have legal existence as a domestic stock life or stock life and disability company as indicated by the amendment, may reorganize by the election of a board of directors and the adoption of bylaws, and proceed to transact the business of such company in accordance with and subject to all laws defining the powers and providing for the regulation of stock life insurance companies.

(b) Provided, however, that no such conversion from a fraternal benefit society to a regular stock or disability company shall be had unless written notice of such proposed change be deposited in the United States mail, registered and postage prepaid, to every member of such fraternal benefit society at their last known post office address at least ninety (90) days before the proposed change or conversion is to be acted upon by the supreme governing body; but notice provided herein councils, or state or division grand lodges composed of delegates from branch councils or subordinate lodges, have by a two-thirds (⅔) vote already authorized or instructed its national council or supreme legislative governing body to change or convert their society into a level premium life insurance or disability company at the time this chapter becomes effective or when such proposed change to a stock life or stock life and disability company, before becoming effective, is submitted to and unanimously approved by the national council or supreme governing body of such fraternal society at a regular meeting of such national council or supreme governing body, or a special meeting of the national council or supreme governing body called by the national or supreme president for the purpose of considering such proposal. The national or supreme president of any such fraternal benefit society may prepare in writing a ballot and, on ninety (90) days' written notice to each member, take a referendum vote in writing as to any such proposed change or conversion. If two-thirds (⅔) of the membership by said referendum vote authorize the national council or supreme legislative governing body to change or covert the society into a stock life or stock life and disability company, then in that event the national council or supreme legislative governing body of said society may proceed to vote said change, and its action in the premises shall be binding upon all members. The amendment to the charter, the method of placing any surplus belonging to any such fraternal benefit society to capital stock, and the method of prorating the stock among membership in a way to protect the interests of all policyholders and members, shall be under the jurisdiction and approval of the commissioner.

HISTORY: Laws, 2001, ch. 362, § 15, eff from and after July 1, 2001.

Cross References — Conversion of fraternal benefit society into stock company, see § 83-29-71.

Conversion of fraternal benefit society into mutual life and disability insurance company, see § 83-31-15.

ARTICLE 7.

CONTRACTUAL BENEFITS.

Sec.
83-30-31. Benefits.
83-30-33. Beneficiaries.
83-30-35. Benefits not attachable.
83-30-37. The benefit contract.
83-30-39. Nonforfeiture benefits, cash surrender values, certificate loans and other options.

§ 83-30-31. Benefits.

(1) A society may provide the following contractual benefits in any form:

(a) Death benefits;

(b) Endowment benefits;

(c) Annuity benefits;

(d) Temporary or permanent disability benefits;

(e) Hospital, medical or nursing benefits;

(f) Funeral benefits;

(g) Monument or tombstone benefits to the memory of deceased members; and

(h) Such other benefits as authorized for life insurers and which are not inconsistent with this chapter.

(2) A society shall specify in its rules those persons who may be issued, or covered by, the contractual benefits in subsection (1), consistent with providing benefits to members and their dependents. A society may provide benefits on the lives of children under the minimum age for adult membership upon application of an adult person.

HISTORY: Laws, 2001, ch. 362, § 16, eff from and after July 1, 2001.

§ 83-30-33. Beneficiaries.

(1) The owner of a benefit contract shall have the right at all times to change the beneficiary or beneficiaries in accordance with the laws or rules of the society unless the owner waives this right by specifically requesting in writing that the beneficiary designation be irrevocable. A society may, through its laws or rules, limit the scope of beneficiary designations and shall provide that no revocable beneficiary shall have or obtain any vested interest in the proceeds of any certificate until the certificate has become due and payable in conformity with the provisions of the benefit contract.

(2) A society may make provision for the payment of funeral benefits to the extent of such portion of any payment under a certificate as might reasonably appear to be due to any person equitably entitled thereto by reason of having incurred expense occasioned by the burial of the member.

(3) If, at the death of any person insured under a benefit contract, there is no lawful beneficiary to whom the proceeds shall be payable, the amount of such benefit, except to the extent that funeral benefits may be paid, shall be payable to the personal representative of the deceased insured, provided that if the owner of the certificate is other than the insured, such proceeds shall be payable to such owner.

HISTORY: Laws, 2001, ch. 362, § 17, eff from and after July 1, 2001.

§ 83-30-35. Benefits not attachable.

No money or other benefit, charity, relief or aid to be paid, provided or rendered by any society, shall be liable to attachment, garnishment or other process, or to be seized, taken, appropriated or applied by any legal or equitable process or operation of law to pay any debt or liability of a member or beneficiary, or any other person who may have a right thereunder, either before or after payment by the society.

HISTORY: Laws, 2001, ch. 362, § 18, eff from and after July 1, 2001.

§ 83-30-37. The benefit contract.

(1) Every society authorized to do business in this state shall issue to each owner of a benefit contract a certificate specifying the amount of benefits

provided thereby. The certificate, together with any riders or endorsements attached thereto, the laws of the society, the application for membership, the application for insurance and declaration of insurability, if any, signed by the applicant, and all amendments to each thereof, shall constitute the benefit contract, as of the date of issuance, between the society and the owner, and the certificate shall so state. A copy of the application for insurance and declaration of insurability, if any, shall be endorsed upon or attached to the certificate. All statements on the application shall be representations and not warranties. Any waiver of this provision shall be void.

(2) Any changes, additions or amendments to the laws of the society duly made or enacted subsequent to the issuance of the certificate, shall bind the owner and the beneficiaries, and shall govern and control the benefit contract in all respects the same as though such changes, additions or amendments had been made prior to and were in force at the time of the application for insurance, except that no change, addition or amendment shall destroy or diminish benefits which the society contracted to give the owner as of the date of issuance.

(3) Any person upon whose life a benefit contract is issued prior to attaining the age of majority shall be bound by the terms of the application and certificate and by all the laws and rules of the society to the same extent as though the age of majority had been attained at the time of application.

(4) A society shall provide in its laws that if its reserves as to all or any class of certificates become impaired its board of directors or corresponding body may require that there shall be paid by the owner to the society the amount of the owner's equitable proportion of such deficiency as ascertained by its board, and that if the payment is not made either (a) it shall stand as an indebtedness against the certificate and draw interest not to exceed the rate specified for certificate loans under the certificates; or (b) in lieu of or in combination with (a), the owner may accept a proportionate reduction in benefits under the certificate. The society may specify the manner of the election and which alternative is to be presumed if no election is made.

(5) Copies of any of the documents mentioned in this section, certified by the secretary or corresponding officer of the society, shall be received in evidence of the terms and conditions thereof.

(6) No certificate shall be delivered or issued for delivery in this state unless a copy of the form has been filed with the commissioner in the manner provided for like policies issued by life and disability insurers in this state. Every life, accident and sickness, health or disability insurance certificate and every annuity certificate issued on or after one (1) year from July 1, 2001, must be filed with the commissioner and shall meet the standard contract provision requirements not inconsistent with this chapter for like policies issued by life and disability insurers in this state, except that a society may provide for a grace period for payment of premiums of one (1) full month in its certificates. The certificate shall also contain a provision stating the amount of premiums which are payable under the certificate and a provision reciting or setting forth the substance of any sections of the society's laws or rules in force at the time

of issuance of the certificate which, if violated, will result in the termination or reduction of benefits payable under the certificate. If the laws of the society provide for expulsion or suspension of a member, the certificate shall also contain a provision that any member so expelled or suspended, except for nonpayment of a premium or within the contestable period for material misrepresentation in the application for membership or insurance, shall have the privilege of maintaining the certificate in force by continuing payment of the required premium.

(7) Benefit contracts issued on the lives of persons below the society's minimum age for adult membership may provide for transfer of control of ownership to the insured at an age specified in the certificate. A society may require approval of an application for membership in order to effect this transfer, and may provide in all other respects for the regulation, government and control of such certificates and all rights, obligations and liabilities incident thereto and connected therewith. Ownership rights prior to such transfer shall be specified in the certificate.

(8) A society may specify the terms and conditions on which benefit contracts may be assigned.

HISTORY: Laws, 2001, ch. 362, § 19, eff from and after July 1, 2001.

§ 83-30-39. Nonforfeiture benefits, cash surrender values, certificate loans and other options.

(1) For certificates issued prior to one (1) year after July 1, 2001, the value of every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall comply with the provisions of law applicable immediately prior to July 1, 2001.

(2) For certificates issued on or after one (1) year from July 1, 2001, for which reserves are computed on the commissioner's 1941 Standard Ordinary Mortality Table, the commissioner's 1941 Standard Industrial Table or the commissioner's 1958 Standard Ordinary Mortality Table, or the commissioner's 1980 Standard Mortality Table, or any more recent table made applicable to life insurers, every paid-up nonforfeiture benefit and the amount of any cash surrender value, loan or other option granted shall not be less than the corresponding amount ascertained in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits based upon such tables.

HISTORY: Laws, 2001, ch. 362, § 20, eff from and after July 1, 2001.

ARTICLE 9.

FINANCIAL.

Sec.
83-30-41. Investments.
83-30-43. Funds.

Sec.
83-30-45. Exemption from insurance laws.
83-30-47. Taxation.

§ 83-30-41. Investments.

A society shall invest its funds only in such investments as are authorized by the laws of this state for the investment of assets of life insurers, and such securities shall be valued accordingly to the methods used in valuing similar securities held by life insurers. Any foreign or alien society permitted or seeking to do business in this state which invests its funds in accordance with the laws of the state, district, territory, country or province in which it is incorporated, shall be held to meet the requirements of this chapter for the investment of funds.

HISTORY: Laws, 2001, ch. 362, § 21, eff from and after July 1, 2001.

Cross References — Approved investments for funds of domestic insurance companies, see §§ 83-19-51, 83-19-53.

Approved investments for assets of fraternal benefit societies, see § 83-29-17.

Approved investments for assets of mutual companies, see § 83-31-29.

§ 83-30-43. Funds.

(1) All assets shall be held, invested and disbursed for the use and benefit of the society and no member or beneficiary shall have or acquire individual rights therein or become entitled to any apportionment on the surrender of any part thereof, except as provided in the benefit contract.

(2) A society may create, maintain, invest, disburse and apply any special fund or funds necessary to carry out any purpose permitted by the laws of such society.

(3) A society may, pursuant to resolution of its supreme governing body, establish and operate one or more separate accounts and issue contracts on a variable basis, subject to the provisions of law regulating life insurers establishing such accounts and issuing such contracts. To the extent the society deems it necessary in order to comply with any applicable federal or state laws, or any rules issued thereunder, the society may adopt special procedures for the conduct of the business and affairs of a separate account, may, for persons having beneficial interests therein, provide special voting and other rights, including without limitation special rights and procedures relating to investment policy, investment advisory services, selection of certified public accountants, and selection of a committee to manage the business and affairs of the account, and may issue contracts on a variable basis to which Section 83-30-37(2) and (4) shall not apply.

HISTORY: Laws, 2001, ch. 362, § 22, eff from and after July 1, 2001.

§ 83-30-45. Exemption from insurance laws.

Except as herein provided, societies shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this state, not only in governmental relations with the state but for every other purpose. No law hereafter enacted shall apply to them unless they be expressly designated therein.

HISTORY: Laws, 2001, ch. 362, § 23, eff from and after July 1, 2001.

Cross References — Laws applicable to domestic insurance companies, see § 83-5-13.

Exclusion of fraternal benefit societies from insurance laws of state, see § 83-29-7.

Exclusion of fraternal societies from laws governing burial associations, see § 83-37-33.

§ 83-30-47. Taxation.

Every society organized or licensed under this chapter is hereby declared to be a charitable and benevolent institution, and all of its funds shall be exempt from every state, county, district, municipal and state tax other than license taxes as defined by Section 27-15-83 and ad valorem taxes on real estate, office equipment and motor vehicles.

HISTORY: Laws, 2001, ch. 362, § 24, eff from and after July 1, 2001.

Cross References — Homestead exemption for property of a fraternal or benevolent organization, see §§ 27-33-17, 27-33-19.

Exemption of fraternal benefit society funds from taxation, see § 83-29-57.

ARTICLE 11.

REGULATION.

Sec.
83-30-49. Valuation.
83-30-51. Annual statement.
83-30-53. Annual license.
83-30-55. Examination of societies; no adverse publications.
83-30-57. Foreign or alien society — admission.
83-30-59. Injunction — liquidation — receivership of domestic society.
83-30-61. Suspension, revocation or refusal of license of foreign or alien society.
83-30-63. Injunction.
83-30-65. Licensing of agents.
83-30-67. Unfair methods of competition and unfair and deceptive acts and practices.

§ 83-30-49. Valuation.

(1) Standards of valuation for certificates issued prior to one (1) year after July 1, 2001, shall be those provided by the laws applicable immediately prior to July 1, 2001.

(2) The minimum standards of valuation for certificates issued on or after one (1) year from July 1, 2001, shall be based on the following tables:

(a) For certificates of life insurance – the commissioner's 1941 Standard Ordinary Mortality Table, the commissioner's 1941 Standard Industrial Mortality Table, the commissioner's 1958 Standard Ordinary Mortality Table, the commissioner's 1980 Standard Ordinary Mortality Table, or any more recent table made applicable to life insurers;

(b) For annuity and pure endowment certificates, for total and permanent disability benefits, for accidental death benefits and for noncancelable accident and health benefits – such tables as are authorized for use by life insurers in this state.

All of the above shall be under valuation methods and standards (including interest assumptions) in accordance with the laws of this state applicable to life insurers issuing policies containing like benefits.

(3) The commissioner may, in his or her discretion, accept other standards for valuation if the commissioner finds that the reserves produced thereby will not be less in the aggregate than reserves computed in accordance with the minimum valuation standard herein prescribed. The commissioner may, in his or her discretion, vary the standards of mortality applicable to all benefit contracts on substandard lives or other extra hazardous lives by any society authorized to do business in this state.

(4) Any society, with the consent of the Commissioner of Insurance of the state of domicile of the society and under such conditions, if any, which the commissioner may impose, may establish and maintain reserves on its certificates in excess of the reserves required thereunder, but the contractual rights of any benefit member shall not be affected thereby.

HISTORY: Laws, 2001, ch. 362, § 25, eff from and after July 1, 2001.

§ 83-30-51. Annual statement.

(1) Every society transacting business in this state shall annually, on or before March 1, unless for cause shown such time has been extended by the commissioner, file with the commissioner a true statement of its financial condition, transactions and affairs for the preceding calendar year. The statement shall be in general form and context as approved by the National Association of Insurance Commissioners for fraternal benefit societies and as supplemented by additional information required by the commissioner.

(2) As part of the annual statement herein required, each society shall, on or before March 1, file with the commissioner a valuation of its certificates in force on December 31 last preceding, provided the commissioner may, in his or her discretion for cause shown, extend the time for filing such valuation for not more than two (2) calendar months. Such valuation shall be done in accordance with the standards specified in Section 83-30-49. Such valuation and underlying data shall be certified by a qualified actuary or, at the expense of the society, verified by the actuary of the department of insurance of the state of domicile of the society. This valuation shall not be considered or regarded as a test of the financial solvency of the society, but as an indication of the ability of the society to pay the benefits promised under its certificates without change

in benefits or in rates of contribution; and each society shall be held to be legally solvent as long as the funds belonging to the society are equal to or in excess of its matured liabilities.

(3) A society neglecting to file the annual statement in the form and within the time provided by this section may be subject to a fine of One Hundred Dollars ($100.00) for each day during which such neglect continues, and its authority to do business in this state may be suspended by the commissioner while such default continues.

HISTORY: Laws, 2001, ch. 362, § 26; Laws, 2003, ch. 315, § 3, eff from and after July 1, 2003.

§ 83-30-53. Annual license.

Societies which are now authorized to transact business in this state may continue such business until the first day of January next succeeding July 1, 2003, and the authority of such societies may hereafter be renewed annually, but in all cases to terminate on the first day of the succeeding January. However, a license so issued shall continue in full force and effect until the new license is issued or specifically refused. For each such license or renewal the society shall pay the commissioner the fees prescribed in Sections 27-15-83 and 83-5-75.

HISTORY: Laws, 2001, ch. 362, § 27; Laws, 2003, ch. 315, § 4, eff from and after July 1, 2003.

Cross References — Annual license and fees for fraternal benefit societies, see § 83-29-27.

§ 83-30-55. Examination of societies; no adverse publications.

(1) The commissioner, or any person he or she may appoint, may examine any domestic, foreign or alien society transacting or applying for admission to transact business in this state in the same manner as authorized for examination of domestic, foreign or alien insurers. Requirements of notice and an opportunity to respond before findings are made public as provided in the laws regulating insurers shall also be applicable to the examination of societies.

(2) The expense of each examination and of each valuation, including compensation and actual expense of examiners, shall be paid by the society examined or whose certificates are valued, upon statements furnished by the Commissioner.

HISTORY: Laws, 2001, ch. 362, § 28, eff from and after July 1, 2001.

Cross References — Power of commissioner to examine insurers, see § 83-5-37.
Examination of domestic insurance companies, see § 83-19-27.

§ 83-30-57. Foreign or alien society — admission.

No foreign or alien society shall transact business in this state without a license issued by the commissioner. Any such society desiring admission to this state shall comply substantially with the requirements and limitations of this chapter applicable to domestic societies. Any such society may be licensed to transact business in this state upon filing with the commissioner:

(a) A duly certified copy of its charter or articles of incorporation;

(b) A copy of its bylaws, certified by its secretary or corresponding officer;

(c) A power of attorney to the commissioner as prescribed in Section 83-29-31;

(d) A statement of its business under oath of its president and secretary or corresponding officers in a form prescribed by the commissioner, duly verified by an examination made by the supervising insurance official of its home state or other state, territory, province or country, satisfactory to the commissioner;

(e) Certification from the proper official of its home state, territory, province or country that the society is legally incorporated and licensed to transact business therein;

(f) Copies of its certificate forms; and

(g) Such other information as the commissioner may deem necessary; and upon a showing that its assets are invested in accordance with the provisions of this chapter.

HISTORY: Laws, 2001, ch. 362, § 29; Laws, 2003, ch. 315, § 1, eff from and after July 1, 2003.

§ 83-30-59. Injunction — liquidation — receivership of domestic society.

(1) When the commissioner upon investigation finds that a domestic society:

(a) Has exceeded its powers;

(b) Has failed to comply with any provision of this chapter;

(c) Is not fulfilling its contracts in good faith;

(d) Has a membership of less than four hundred (400) after an existence of one (1) year or more; or

(e) Is conducting business fraudulently or in a manner hazardous to its members, creditors or the public;

the commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The commissioner shall simultaneously issue a written notice to the society requiring that the deficiency or deficiencies which exist be corrected. After such notice the society shall have a thirty-day period in which to comply with the commissioner's request for correction, and if the society fails to comply, the commissioner shall take such action as is necessary and appropriate under Chapter 24 of Title 83.

(2) The commissioner may take such action as is necessary and appropriate under this section as respects a domestic society which shall voluntarily determine to discontinue business.

HISTORY: Laws, 2001, ch. 362, § 30, eff from and after July 1, 2001.

Cross References — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

§ 83-30-61. Suspension, revocation or refusal of license of foreign or alien society.

(1) When the commissioner upon investigation finds that a foreign or alien society transacting or applying to transact business in this state:

(a) Has exceeded its powers;

(b) Has failed to comply with any of the provisions of this chapter;

(c) Is not fulfilling its contracts in good faith; or

(d) Is conducting its business fraudulently or in a manner hazardous to its members or creditors or the public;

the commissioner shall notify the society of such deficiency or deficiencies and state in writing the reasons for his or her dissatisfaction. The commissioner shall at once issue a written notice to the society requiring that the deficiency or deficiencies which exist are corrected. After such notice the society shall have a thirty-day period in which to comply with the commissioner's request for correction, and if the society fails to comply the commissioner shall notify the society of such findings of noncompliance and require the society to show cause on a date named why its license should not be suspended, revoked or refused. If on such date the society does not present good and sufficient reason why its authority to do business in this state should not be suspended, revoked or refused, the commissioner may suspend or refuse the license of the society to do business in this state until satisfactory evidence is furnished to the commissioner that such suspension or refusal should be withdrawn or the commissioner may revoke the authority of the society to do business in this state.

(2) Nothing contained in this section shall be taken or construed as preventing any such society from continuing in good faith all contracts made in this state during the time such society was legally authorized to transact business herein.

HISTORY: Laws, 2001, ch. 362, § 31, eff from and after July 1, 2001.

§ 83-30-63. Injunction.

No application for injunction against or proceeding for the dissolution of or the appointment of a receiver for any domestic society, or lodge thereof, or against any foreign or alien society, shall be entertained in any court of this state unless made by the Attorney General or the commissioner.

HISTORY: Laws, 2001, ch. 362, § 32, eff from and after July 1, 2001.

§ 83-30-65. Licensing of agents.

(1) Agents of societies shall be licensed in accordance with the provisions of Chapter 17 of Title 83.

(2) No examination or license shall be required of any regular salaried officer, employee or member of a licensed society who devotes substantially all of his or her services to activities other than the solicitation of fraternal insurance contracts from the public, and who receives for the solicitation of such contracts no commission or other compensation directly dependent upon the amount of business obtained.

HISTORY: Laws, 2001, ch. 362, § 33, eff from and after July 1, 2001.

Cross References — Insurance agents, solicitors or adjusters, see §§ 83-17-1 et seq.

§ 83-30-67. Unfair methods of competition and unfair and deceptive acts and practices.

Every society authorized to do business in this state shall be subject to the provisions of Chapter 5 of Title 83 relating to unfair practices; provided, however, that nothing therein shall be construed as applying to or affecting the right of any society to determine its eligibility requirements for membership, or be construed as applying to or affecting the offering of benefits exclusively to members or persons eligible for membership in the society by a subsidiary corporation or affiliated organization of the society.

HISTORY: Laws, 2001, ch. 362, § 34, eff from and after July 1, 2001.

Cross References — General provisions relative to insurance and insurance companies, see § 83-5-1 et seq.

ARTICLE 13.

MISCELLANEOUS PROVISIONS.

Sec.	
83-30-69.	Service of process.
83-30-71.	Penalties.
83-30-73.	Exemption of certain societies.
83-30-75.	Review.
83-30-77.	Severability.

§ 83-30-69. Service of process.

(1) Every society authorized to do business in this state shall appoint in writing the commissioner and each successor in office to be its true and lawful attorney upon whom all lawful process in any action or proceeding against it shall be served, and shall agree in such writing that any lawful process against it which is served on such attorney shall be of the same legal force and validity as if served upon the society, and that the authority shall continue in force so long as any liability remains outstanding in this state. Copies of such appointment, certified by the commissioner, shall be deemed sufficient evidence thereof and shall be admitted in evidence with the same force and effect as the original thereof might be admitted.

(2) Service shall only be made upon the commissioner, or if absent, upon the person in charge of his or her office. It shall be made in duplicate and shall constitute sufficient service upon the society. When legal process against a society is served upon the commissioner, he shall forthwith forward the duplicate copy by certified mail, prepaid, directed to the secretary or corresponding officer. No such service shall require a society to file its answer, pleading or defense in less than thirty (30) days from the date of mailing the copy of the service to a society. Legal process shall not be served upon a society except in the manner herein provided.

(3) At the time of serving any process upon the commissioner, the plaintiff or complainant in the action shall pay to the commissioner a fee of Twenty-five Dollars ($25.00).

HISTORY: Laws, 2001, ch. 362, § 35; Laws, 2003, ch. 315, § 2, eff from and after July 1, 2003.

§ 83-30-71. Penalties.

(1) A person who shall knowingly or willfully make any false or fraudulent statement or representation in or relating to any application for membership or for the purpose of obtaining money from or a benefit in any society, shall be guilty of a misdemeanor and upon conviction thereof be fined not less than One Hundred Dollars ($100.00) nor more than Five Hundred Dollars ($500.00), or imprisonment in the county jail not less than thirty (30) days nor more than one (1) year, or both, in the discretion of the court.

(2) Any person who shall willfully make a false or fraudulent statement in any verified report or declaration under oath required or authorized by this chapter, or of any material fact or thing contained in a sworn statement concerning the death or disability of an insured for the purpose of procuring payment of a benefit named in the certificate, shall be guilty of perjury and shall be subject to the penalties therefor prescribed by law.

(3) Any person who solicits membership for, or in any manner assists in procuring membership in, any society not licensed to do business in this state shall upon conviction thereof be fined not less than Fifty Dollars ($50.00) nor more than Two Hundred Dollars ($200.00).

(4) Any person guilty of a willful violation of, or neglect or refusal to comply with, the provisions of this chapter for which a penalty is not otherwise prescribed shall upon conviction thereof be fined not exceeding Two Hundred Dollars ($200.00).

HISTORY: Laws, 2001, ch. 362, § 36, eff from and after July 1, 2001.

Cross References — Perjury generally, see §§ 99-9-59 through 99-9-65.
Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

§ 83-30-73. Exemption of certain societies.

(1) Nothing contained in this chapter shall be so construed as to affect or

apply to grand or subordinate lodges of Masons, Odd Fellows, or Knights of Pythias exclusive of the insurance department of the supreme lodge Knights of Pythias, and the Junior Order of United American Mechanics exclusive of beneficiary degree or insurance branch of the National Council Junior Order United American Mechanics, or societies which admit to membership only persons engaged in one or more hazardous occupation in the same or similar lines of business. The Commissioner of Insurance may require from any society such information as will enable him to determine whether such society is exempt from the provisions of this chapter.

(2) Any larger fraternal benefit society heretofore organized and incorporated and operating within the definition set forth in Section 83-30-1 providing benefits in case of death or disability resulting solely from accidents, but which does not obligate itself to pay death or sick benefits, may be licensed under the provisions of this chapter, and shall have all the privileges and shall be subject to all the provisions and regulations of this chapter, except that the provisions of this chapter as to valuations of benefit certificates shall not apply to such society.

(3) The commissioner may require from any society or association, by examination or otherwise, such information as will enable the commissioner to determine whether such society or association is exempt from the provisions of this chapter.

(4) Societies exempted under the provisions of this section shall also be exempt from all other provisions of the insurance laws of this state.

HISTORY: Laws, 2001, ch. 362, § 37, eff from and after July 1, 2001.

§ 83-30-75. Review.

All decisions and findings of the commissioner made under the provisions of this chapter shall be subject to review as set forth in Section 83-6-41 or otherwise in Title 83 as respects the particular subject matter involved.

HISTORY: Laws, 2001, ch. 362, § 38, eff from and after July 1, 2001.

Cross References — Appeals to chancery court and petition for writ in nature of mandamus or peremptory mandamus, see § 83-6-41.

§ 83-30-77. Severability.

If any provision of this chapter or the application of such provision to any circumstance is held invalid, the remainder of the chapter or the application of the provision to other circumstances, shall not be affected thereby.

HISTORY: Laws, 2001, ch. 362, § 39, eff from and after July 1, 2001.

CHAPTER 31.

MUTUAL COMPANIES

In General. 83-31-1
Mississippi Mutual Insurance Company Conversion, Reorganization and Merger Act. 83-31-101

IN GENERAL

Sec.	
83-31-1.	Formation.
83-31-3.	Articles of association.
83-31-5.	Name must contain the word "mutual."
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§ 83-31-1. Formation.

Any number of persons not less than three (3), a majority of whom shall be bona fide residents of this state, by complying with the provisions of this chapter, may become, together with others who may hereafter be associated with them or their successors, a body corporate for the purpose of carrying on the business of mutual insurance as herein provided.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209a; 1930, § 5269; 1942, § 5783; Laws, 1918, ch. 157; Laws, 1997, ch. 410, § 14, eff from and after July 1, 1997.

Cross References — Mutual insurance holding company exemption from certain provisions, see § 83-31-173.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 112.	44 C.J.S., Insurance §§ 166, 167.

§ 83-31-3. Articles of association.

Any persons proposing to form any such company shall subscribe and acknowledge articles of association specifying:

(a) The name, the purpose for which formed, and the location of its principal or home office;

(b) The names and addresses of those composing the board of directors in which the management shall be vested until the first meeting of the members;

(c) The names and places of residence of the incorporators.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209b; 1930, § 5270; 1942, § 5784; Laws, 1918, ch. 157.

Cross References — Organization of domestic insurance company, see §§ 83-19-1 et seq.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 115.	44 C.J.S., Insurance § 169.

§ 83-31-5. Name must contain the word "mutual."

No name shall be adopted by such company which does not contain the word "mutual," or which is so similar to any name already in use by any such existing corporation, company, or association, organized or doing business in the United States, as to be confusing or misleading.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209c; 1930, § 5271; 1942, § 5785; Laws, 1918, ch. 157.

RESEARCH REFERENCES

CJS.
44 C.J.S., Insurance § 167.

§ 83-31-7. Commissioner of Insurance to approve articles.

Such articles of association shall be submitted to the commissioner of insurance, herein designated "commissioner," and if prepared in accordance with this chapter, he shall approve and file the same in his office.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209d; 1930, § 5272; 1942, § 5786; Laws, 1918, ch. 157.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 115.	44 C.J.S., Insurance § 169.

§ 83-31-9. Corporate powers.

The company shall have legal existence from the approval and filing of such articles in the office of the commissioner. The board of directors named in such articles may thereupon adopt bylaws and proceed to transact the business of such company, provided that no insurance shall be put into force until the company has been licensed to transact insurance as provided by this chapter. The company shall have succession for the time limited in its articles of association; may determine the manner of calling and conducting the meetings and the mode of voting by proxy; may elect all necessary officers and prescribe the duties and tenure of officers; may sue and be sued and prosecute and be prosecuted to judgment and satisfaction before any court; may have a corporate seal; may contract and be contracted with within the limits of its corporate powers; may buy, hold and sell real estate and personal property; may borrow money and secure the payment of same by mortgage or otherwise.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209e; 1930, § 5273; 1942, § 5787; Laws, 1918, ch. 157; Laws, 1993, ch. 309, § 1, eff from and after passage (approved March 4, 1993).

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 112.	44 C.J.S., Insurance § 172.

§ 83-31-10. Existence in perpetuity; extension of time of life to perpetuity.

(1) Whenever the period of existence of a mutual insurance company created with a life of fifty (50) years expires before March 4, 1993, then every such mutual company that continues to do business for ninety (90) days after March 4, 1993, by the doing of such business shall be deemed to have accepted an extension of the time of life of such mutual company to that of perpetuity. Such mutual company shall continue in existence as a de jure mutual company as fully and completely as if the articles of association had been thus amended before the end of the original fifty-year period. Likewise, whenever the period of existence of a mutual company created for a period of fifty (50) years expires hereafter, if such mutual company continues to do business thereafter for a period of ninety (90) days, the same shall operate as an acceptance of an extension of time of the life of such mutual company to that of perpetuity. Such mutual company shall continue in existence as a de jure mutual company as fully and completely as if the articles of association had been thus amended before the end of the original fifty-year period.

(2) When a mutual insurance company amends its articles of association

in accordance with this section, it shall file within ninety (90) days thereafter in the Office of the Commissioner of Insurance a copy of the amended articles of association to show the extension of the time of life of such mutual company.

(3) This section shall in no way nullify any suit or claim accrued or to accrue before March 4, 1993.

HISTORY: Laws, 1993, ch. 309, § 2, eff from and after passage (approved March 4, 1993).

Cross References — Articles of association, see § 83-31-3.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 75, 76.
10 Am. Jur. Legal Forms 2d, Insurance, Form 149:22.

CJS.
44 C.J.S., Insurance § 167.

§ 83-31-11. Kind of insurance authorized.

Any company organized under the provisions of this chapter is empowered and authorized to make contracts of insurance or to reinsure or accept reinsurance, or any portion thereof, to the extent specified in its articles of association for the kinds of insurance following:

(a) **Fire insurance.** Against loss or damage to property and loss of use and occupancy by fire, lightning, hail, tempest, flood, earthquake, frost or snow, explosion, fire ensuing, and explosion, no fire ensuing, except explosion by steam boilers or flywheel; against loss or damage by water caused by the breakage or leakage of sprinklers, pumps, or other apparatus, water pipes, plumbing, or their fixtures, erected for extinguishing fires, and against accidental injury to such sprinklers, pumps, other apparatus, water pipes, plumbing, or fixtures; against the risks of inland transportation and navigation; upon automobiles, whether stationary or operated under their own power, against loss or damage by any of the causes or risks specified in this subsection, including also transportation, collision, liability, for damage to property resulting from owning, maintaining, or using automobiles, and including burglary and theft but not including loss or damage by risk of bodily injury to the person.

(b) **Liability insurance.** Against loss, expense, or liability by risk of bodily injury to death by accident, disability, sickness, or disease suffered by others for which the insured may be liable or have assumed liability, including workman's compensation.

(c) **Disability insurance.** Against bodily injury or death by accident and disability by sickness.

(d) **Automobile insurance.** Against any or all loss, expense, and liability resulting from the ownership, maintenance, or use of any automobile or other vehicle, provided no policies shall be issued under this subsection against the hazard of fire alone.

(e) **Steam boiler insurance.** Against loss or liability to persons or property resulting from explosions or accidents to boilers, containers, pipes, engines, flywheels, elevators, and machinery in connection therewith, and against loss of use and occupancy caused thereby, and to make inspection and issue certificates of inspection thereon.

(f) **Use and occupancy insurance.** Against loss from interruption of trade or business which may be the result of any accident or casualty.

(g) **Life insurance.** To carry on the business commonly known as life insurance on the mutual plan, or disability insurance; to contract for the payment of endowments or annuities, or make and enter into such other contracts conditioned upon the continuance or cessation of human life.

(h) **Miscellaneous insurance.** Against loss or damage by any hazard upon any risk not provided for in this section, which is not prohibited by statute or at common law from being the subject of insurance.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209f; 1930, § 5274; 1942, § 5788; Laws, 1918, ch. 157; Laws, 1924, ch. 191.

Cross References — Purposes for organization of insurance companies, see §§ 83-19-1, 83-19-3.

Capital required for various classes of companies, see § 83-19-31.

RESEARCH REFERENCES

ALR.

Property insurance: construction and effect of provision excluding loss caused by earth movement or earthquake. 44 A.L.R.3d 1316.

Property insurance on aircraft; risks and losses covered. 48 A.L.R.3d 1120.

"Vehicle" or "land vehicle" within meaning of insurance policy provision defining risks covered or excepted. 65 A.L.R.3d 824.

Boiler and machinery insurance; risks and losses covered by policy or provision expressly covering boilers and machinery. 49 A.L.R.4th 336.

What is "flood" within exclusionary clause of property damage policy. 78 A.L.R.4th 817.

National Flood Insurance risks and coverage. 81 A.L.R. Fed. 416.

Am. Jur.

43 Am. Jur. 2d, Insurance § 117.

5 Am. Jur. Proof of Facts 3d, Negligent Failure to Install or Maintain Smoke Alarm or Sprinkler System, §§ 1 et seq.

CJS.

44 C.J.S., Insurance § 172.

Practice References.

Business Law Monographs, Volume IN1 – Business Uses of Life Insurance (Matthew Bender).

Business Law Monographs, Volume IN2 —Casualty and Liability Insurance (Matthew Bender).

§ 83-31-13. May reinsure certain risks.

(1) A mutual company transacting fire, casualty, or multiple line insurance business under the laws of this state, with the approval of the commissioner of insurance, may reinsure all risks undertaken by it in any company authorized to transact a similar class of insurance business in this state, and may transfer to the company assuming such risks all or such of its assets, reserves, liabilities, and obligations of every character as the agreement approved by the commissioner shall provide.

(2) This section shall not prevent such a company from reinsuring any risks or fractional parts thereof, not situated in this state, in any company licensed by the state in which such risks are located.

HISTORY: Codes, 1942, § 5788.5; Laws, 1960, ch. 373, §§ 1-3.

RESEARCH REFERENCES

Am. Jur.
44A Am. Jur. 2d, Insurance §§ 1842 et seq.

CJS.
46 C.J.S., Insurance §§ 1720 et seq.

§ 83-31-15. Fraternal societies may be converted.

Any fraternal benefit society organized under the laws of this state may be converted into a mutual life or mutual life and disability insurance company, so as to come within the provisions of all laws governing mutual companies and operate under this chapter upon the terms and conditions as follows:

Whenever the supreme governing legislative body of any fraternal benefit society incorporated under the laws of this state shall, by two-thirds (⅔) vote, determine that a change or conversion from a fraternal benefit society to a regular mutual life or disability insurance company shall be to the best interests of the society and its members, or whenever a majority of the members in good standing of any such domestic fraternal benefit society shall, in writing, signify their desire for such conversion, then, in either event, said fraternal benefit society may adopt and file with the insurance commissioner of Mississippi an amendment to its articles of incorporation, authorizing it to be converted from a fraternal to a domestic mutual life or disability insurance company; and said amendment shall become operative upon its approval by and filing with the insurance commissioner, unless a later time be provided in said amendment. If the amendment is approved by the insurance commissioner, he shall issue his certificate of approval in writing. Thereafter the company shall have legal existence as a domestic mutual life or disability insurance company, may reorganize by the election of a board of directors and the adoption of bylaws, and proceed to transact the business of such company in accordance with and be subject to all of the terms and provisions of this chapter governing mutual companies.

Provided, however, that no such conversion from a fraternal benefit society to a regular mutual life or disability insurance company shall be had unless written notice of such proposed change be deposited in the United States mail, registered and postage prepaid, to each member of such fraternal benefit society at his last known post office address at least ninety (90) days before the proposed change or conversion is to be acted upon by said supreme governing body; but the notice provided herein shall not apply to or be required of any fraternal benefit society whose district councils, or state or division grand lodges composed of delegates from branch councils or subordinate lodges, have by a two-thirds (⅔) vote already authorized or instructed its national council or supreme legislative governing body to change or convert their society into said mutual life and disability company before April 10, 1924.

HISTORY: Codes, 1930, § 5275; 1942, § 5789; Laws, 1924, ch. 191.

Cross References — Conversion of fraternal societies into stock companies, see § 83-29-71.

Conversion of fraternal benefit societies into stock companies, see § 83-29-71.

Conversion of larger fraternal benefit society into mutual or stock insurer, see § 83-30-29.

JUDICIAL DECISIONS

1. In general.

The conversion of a fraternal society into a mutual life and disability company destroys the immunity provided by Code 1930, § 5235 [Code 1942, § 5749]; and consequently, a mutual insurance company, ceasing to be a fraternal society, was bound by the acts of its agents in misleading an insured as to the extent of disability necessary to entitle him to file a claim therefor. Columbian Mut. Life Ins. Co. v. Gipson, 185 Miss. 890, 189 So. 799, 1939 Miss. LEXIS 192 (Miss. 1939).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 117.

CJS.

44 C.J.S., Insurance § 168.

§ 83-31-17. Principal office.

Any mutual life insurance company may acquire, own, or maintain a principal office, by and with the written consent of the insurance commissioner, in any state in which said company is admitted to do business, and may provide that the meetings of its board of directors or governing body may be held at said principal office. All business transacted at said principal office shall be as valid in all respects as if the meetings of the board of directors or governing body were held in this state.

HISTORY: Codes, 1930, § 5276; 1942, 5790; Laws, 1924, ch. 191.

Cross References — Meeting of governing body of fraternal societies outside state, see § 83-29-33.

RESEARCH REFERENCES

CJS.

44 C.J.S., Insurance § 167.

§ 83-31-19. Certain companies not affected.

The provisions of this chapter shall not apply to foreign mutual reserve insurance companies doing business in this state upon the legal reserve plan.

HISTORY: Codes, 1930, § 5277; 1942, § 5791; Laws, 1924, ch. 191.

Cross References — Admission of foreign mutual companies, see § 83-31-39.

§ 83-31-21. License.

No such company shall issue policies or transact any business of insurance unless it shall hold a license from the commissioner authorizing the transaction of such business. Such license shall not be issued until and unless the company shall have in paid-up or contributed surplus the amount required in Section 83-19-73.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209g; 1930, § 5278; 1942, § 5792; Laws, 1918, ch. 157; Laws, 1956, ch. 336, § 2; Laws, 1997, ch. 410, § 16, eff from and after July 1, 1997.

Editor's Notes — Section 83-19-73 referred to in this section was repealed by Laws, 1998, ch. 323, § 9, eff from and after July 1, 1998. For similar provisions, see § 83-19-31.

Cross References — Capital and surplus requirements, see § 83-19-31.

§ 83-31-23. Corporations and associations may hold policies.

Any public or private corporation, board, or association in this state or elsewhere may make application, enter into agreements for, and hold policies in any such mutual insurance company. Any officer, stockholder, trustee, or legal representative of any such corporation, board, association, or estate may be recognized as acting for or on its behalf for the purpose of such membership; but shall not be personally liable upon such contract of insurance by reason of acting in such representative capacity. The right of any corporation organized under the laws of this state to participate as a member of any such mutual insurance company is hereby declared to be incidental to the purpose for which such corporation is organized, and as much granted as the rights and powers expressly conferred.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209h; 1930, § 5279; 1942, § 5793; Laws, 1918, ch. 157.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 122.

CJS.
44 C.J.S., Insurance § 170.

§ 83-31-25. Voting of members.

Every member of the company shall be entitled to one vote, or to a number of votes based upon the insurance in force, the number of policies held, or the amount of premiums paid, as may be provided in the bylaws.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209i; 1930, § 5280; 1942, § 5794; Laws, 1918, ch. 157.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 123.	44 C.J.S., Insurance § 170.

§ 83-31-27. Premiums.

The maximum premium payable by any member shall be expressed in the policy or in the application for the insurance. Such maximum premium may be a cash premium and an additional contingent premium not less than the cash premium, or may be solely a cash premium. No policy shall be issued for a cash premium without an additional contingent premium unless the company has a surplus which is not less in amount than the capital stock required of domestic stock insurance companies transacting the same kind of insurance.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209j; 1930, § 5281; 1942, § 5795; Laws, 1918, ch. 157.

Cross References — Capital required for various classes of companies, see § 83-19-31.

RESEARCH REFERENCES

CJS.
44 C.J.S., Insurance §§ 550 et seq.

§ 83-31-29. Investment of assets.

No such company shall invest any of its assets except in accordance with the laws of this state relating to the investment of the assets of domestic stock companies transacting the same kind of insurance.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209k; 1930, § 5282; 1942, § 5796; Laws, 1918, ch. 157.

Cross References — Authorized investment of funds by domestic insurance companies, see § 83-19-51.
Authorized investment of funds by fraternal societies, see § 83-29-17.
Approved investments for assets of larger fraternal benefit societies, see § 83-30-41.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 118.	44 C.J.S., Insurance § 173.

§ 83-31-31. Reserves and unearned premiums.

Such company shall maintain unearned premium and other reserves separately for each kind of insurance, upon the same basis as that required of domestic stock insurance companies transacting the same kind of insurance; provided, that any reserve for losses or claims based upon the premium income shall be computed upon the net premium after deducting any so-called dividend or premium returned or credited to the member.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209l; 1930, § 5283; 1942, § 5797; Laws, 1918, ch. 157.

Cross References — Reserves required of insurance companies, see § 83-5-23. Computation of reserve liabilities of life insurance companies, see §§ 83-7-21 et seq.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 71.	44 C.J.S., Insurance §§ 174, 175.

§ 83-31-33. Deficiency in assets.

Such company not possessed of assets at least equal to the unearned premium reserve and other liabilities shall make an assessment upon its members liable to assessment to provide for such deficiency, such assessment to be against each such member in proportion to such liability as expressed in his policy. The commissioner may, by written order, relieve the company from an assessment or other proceedings to restore such assets during the time fixed in such order.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209m; 1930, § 5284; 1942, § 5798; Laws, 1918, ch. 157.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 118.	44 C.J.S., Insurance § 173.

§ 83-31-35. Money advanced by officers or members.

Any director, officer, or member of any such company, or any other person, may advance to such company any sum or sums of money necessary for the purpose of its business or to enable it to comply with any of the requirements of the law. Such moneys and such interest thereon as may have been agreed upon, not exceeding ten percent (10%) per annum, shall not be a liability or claim against the company or any of its assets, except as herein provided, and shall be repaid only out of the surplus earnings of such company. No commission nor promotion expenses shall be paid in connection with the advance of any such money to the company, and the amount of such advance shall be reported in each annual statement.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209n; 1930, § 5285; 1942, § 5799; Laws, 1918, ch. 157.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 142, 143 et seq.

CJS.
44 C.J.S., Insurance § 176.

§ 83-31-37. Delivery of policies through licensed agents.

Such mutual company shall comply with the provisions of any law applicable to any stock insurance companies effecting the same kind of insurance requiring that policies be countersigned and delivered through a licensed agent. This requirement shall not apply to any policy of such mutual company on which no commission shall be paid to any local agent. Such mutual company may insert, in any form of policy prescribed by the law of this state, such provisions or conditions required by its plan of insurance which are not inconsistent or in conflict with any law of this state. Such policy, in lieu of conforming to the language and form prescribed by such law, may conform thereto in substance, if such policy includes a provision or endorsement reciting that the policy shall be construed as if in the language and form prescribed by such law, and a copy of such policy and endorsement, if any, shall have been first filed with and shall not have been disapproved by the commissioner.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209o; 1930, § 5286; 1942, § 5800; Laws, 1918, ch. 157; Laws, 2001, ch. 510, § 33, eff from and after January 1, 2002.

Cross References — Licensing of insurance agents, see § 83-17-5.
Prohibition against paying commission to unauthorized agent, see § 83-17-7.
Requirement that insurance policies be written by resident local agents, see § 83-17-21.

RESEARCH REFERENCES

ALR.
Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

CJS.
44 C.J.S., Insurance § 392.

§ 83-31-39. Admission of foreign mutual companies.

Any mutual insurance company organized outside of this state and authorized to transact the business of insurance on the mutual plan in any state, district, or territory, except foreign mutual life insurance companies doing business upon the legal reserve plan, shall be admitted and licensed to transact the kinds of insurance authorized by its charter or articles of association to the extent and with the powers and privileges specified in this chapter when it shall be solvent under this chapter and shall have complied with the following requirements:

(a) Filed with the commissioner a certified copy of its charter or articles of association;

(b) Filed with the commissioner a copy of its bylaws certified to by its secretary;

(c) Appointed the commissioner its agent for the service of process in any action, suit, or proceedings in any court of this state, which authority shall continue as long as any liability shall remain outstanding in this state;

(d) Filed a financial statement under oath, in such form as the commissioner may require, and have complied with other provisions of law applicable to the filing of papers and furnishing information by stock companies on application for authority to transact the same kind of insurance;

(e) If organized without the United States, make and maintain the deposit required of stock insurance companies formed without the United States transacting the same kind of insurance. Upon compliance by any such foreign company with the provisions in this section, such company shall be licensed and authorized to transact business in this state, subject to all the provisions of law relating to information to and examinations by the commissioner, annual reports, taxes, and the renewal of license applicable to stock insurance companies transacting the same kind of insurance, except as otherwise provided in this chapter.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209p; 1930, § 5287; 1942, § 5801; Laws, 1918, ch. 157.

Cross References — Requirements for admission of foreign insurance companies generally, see §§ 83-21-1, 83-21-3.

Laws applicable to foreign insurance companies, see § 83-21-7.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 85.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 22 (petition or application for writ of mandamus to compel issuance of license to foreign corporation to conduct insurance business within state).

CJS.

44 C.J.S., Insurance §§ 129, 130.

§ 83-31-41. Annual reports.

Every such mutual insurance company shall make its annual report in such form and submit to such examinations as may be required by the commissioner of insurance. As far as practicable, such examinations of foreign mutual insurance companies shall be made in co-operation with the insurance departments of other states, and the forms of annual report shall be such as are in general use throughout the United States.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209q; 1930, § 5288; 1942, § 5802; Laws, 1918, ch. 157.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance § 128.

§ 83-31-43. Applicability of other laws.

(1) Except as expressly exempted by this chapter, all mutual companies organized or admitted to do business in this state shall be subject to any and all other laws of this state governing insurance companies.

(2) All laws enacted whereby the Commissioner of Insurance of the State of Mississippi is granted general authority as to reports, audits, regulations, supervisions, reorganizations or liquidations shall be applicable to all public and private corporations, boards or associations organized under the provisions of this title and chapter regardless of any provisions of law or statute to the contrary.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209r; 1930, § 5289; 1942, § 5803; Laws, 1918, ch. 157; Laws, 1994, ch. 422, § 3, eff from and after July 1, 1994.

JUDICIAL DECISIONS

1. In general.

Where statute provided that mutual insurance company should pay premium tax in lieu of all licenses and taxes except ad valorem taxes on realty, mutual company held not liable for privilege tax authorized by general statute. Gulley v. Lumbermen's Mut. Casualty Co., 176 Miss. 388, 166 So. 541, 168 So. 609, 1936 Miss. LEXIS 102 (Miss. 1936).

Statute relating to collection of privilege and premium taxes from insurance companies, providing that section [Code 1942, § 5803] covering premium taxes should apply to mutual insurance companies, held to authorize collection of privilege tax from mutual company, notwithstanding prior statute providing for payment of premium tax by mutual companies in lieu of other taxes. Gulley v. Lumbermen's Mut. Casualty Co., 176 Miss. 388, 166 So. 541, 168 So. 609, 1936 Miss. LEXIS 102 (Miss. 1936).

§ 83-31-45. Taxation of premium receipts.

(1) The taxable premium or premium receipts of any mutual insurance company organized or admitted in this state under this chapter for the purpose of taxation under any law of this state shall be the gross premiums received for direct insurance upon property or risks in this state, deducting premiums upon policies not taken and premiums returned on cancelled policies and also any refund or return made to the policyholder other than for loss. Such mutual insurance companies shall pay into the State Treasury through the State Tax Commission a premium tax in accordance with the provisions of Section 27-15-103 et seq.

(2) In the event that the Mississippi Supreme Court or another court finally adjudicates that any tax levied prior to July 1, 1985, under the provisions of this section was collected unconstitutionally and that a liability for a credit or refund for such collection has accrued, then the rate of tax set

forth above shall be increased to four percent (4%) for a period of six (6) years beginning July 1 following such adjudication.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209s; 1930, § 5290; 1942, § 5804; Laws, 1918, ch. 157; Laws, 1978, ch. 441, § 5; Laws, 1982, ch. 351, § 17; Laws, 1983, ch 452, § 1; Laws, 1985, ch. 530, § 4; Laws, 1997, ch. 324, § 4, eff from and after July 1, 1997.

Editor's Notes — Section 20 of ch. 351, Laws of 1982, effective July 1, 1982, provides as follows:

"SECTION 20. Nothing in this act shall affect or defeat any claim, assessment, appeal, suit, right or cause of action for taxes due or accrued under any section contained herein prior to the date on which this act becomes effective, whether such assessments, appeals, suits, claims or actions shall have been begun before the date on which this act becomes effective, or shall thereafter be begun; and the provisions of any section contained herein are expressly continued in full force, effect and operation for the purpose of the assessment and collection of any taxes due or accrued thereunder prior to the date on which this act becomes effective, or the filing of reports, and for the imposition of any penalties, forfeitures or claims for failure to comply therewith."

Section 2 of ch. 452, Laws of 1983, effective from and after April 1, 1983, provides as follows:

"SECTION 2. Nothing in this act shall affect or defeat any claim, assessment, appeal, suit, right or cause of action for taxes due or accrued under the insurance premium tax laws prior to the date on which this act becomes effective, whether such assessments, appeals, suits, claims or actions shall have been begun before the date on which this act becomes effective or shall thereafter be begun; and the provisions of the insurance premium tax laws are expressly continued in full force, effect and operation for the purpose of the assessment, collection and enrollment of liens for any taxes due or accrued and executing of any warrant under said laws prior to the date on which this act becomes effective, and for the imposition of any penalties, forfeitures or claims for failure to comply therewith."

Section 27-3-4 provides that the terms "'Mississippi State Tax Commission,' 'State Tax Commission,' 'Tax Commission' and 'commission' appearing in the laws of this state in connection with the performance of the duties and functions by the Mississippi State Tax Commission, the State Tax Commission or Tax Commission shall mean the Department of Revenue."

Cross References — Premium tax, see §§ 27-15-103 et seq.

Reduction in premium tax for insurers who make qualifying Mississippi investments, see § 27-15-129.

Credit for overpayment of taxes, see § 27-15-131.

Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

JUDICIAL DECISIONS

1. In general.

Appellee, a domestic mutual insurance company, is taxable under Code 1930, § 5290 [Code 1942, § 5809].The contention that section 107, ch. 20, Gen. Loc. and Priv. Laws 1935, establishes a different rule is not well taken, because section 106 of that chapter expressly excepts and takes out of said chapter 20 domestic insurance companies taxed as otherwise provided by law. Williams v. North American Mut. Ins. Co., 172 So. 334 (Miss. 1937).

Where statute provided that mutual insurance company should pay premium tax in lieu of all licenses and taxes except ad valorem taxes on realty, mutual company held not liable for privilege tax authorized by general statute. Gulley v. Lumbermen's Mut. Casualty Co., 176 Miss. 388, 166 So. 541, 168 So. 609, 1936 Miss. LEXIS 102 (Miss. 1936).

Statute relating to collection of privilege and premium taxes from insurance companies, providing that section [Code 1942, § 5804] covering premium taxes should apply to mutual insurance companies, held to authorize collection of privilege tax from mutual company, notwithstanding prior statute providing for payment of premium tax by mutual companies in lieu of other taxes. Gulley v. Lumbermen's Mut. Casualty Co., 176 Miss. 388, 166 So. 541, 168 So. 609, 1936 Miss. LEXIS 102 (Miss. 1936).

RESEARCH REFERENCES

Am. Jur.
71 Am. Jur. 2d, State and Local Taxation §§ 368 et seq.

CJS.
44 C.J.S., Insurance §§ 118-120, 131, 132.

§ 83-31-47. Merger with foreign mutual insurance company.

(1) A domestic mutual insurance company may effect a merger with one or more domestic mutual insurance companies, or with one or more foreign mutual insurance companies, if such merger is authorized by the laws of the state under which each such foreign company is organized.

(2) The Commissioner of Insurance shall review and approve the plan to merge the mutual insurance companies before submission of the plan to the eligible members for their consideration and vote. The plan must be approved by two-thirds (⅔) of those eligible members who vote in person or by proxy at a duly called eligible members' meeting to consider the plan of merger. The commissioner may require mutual companies to comply with appropriate requirements as that analogous to those of a stock company merger under Sections 83-6-24 and 83-19-99.

HISTORY: Laws, 1998, ch. 576, § 41, eff from and after July 1, 1998.

Cross References — Good faith failure to provide notice, see § 83-31-135.

Applicability of requirements of this section to merger or consolidation of mutual insurance holding company, see § 83-31-157.

Mutual insurance holding company investments, see § 83-31-167.

MISSISSIPPI MUTUAL INSURANCE COMPANY CONVERSION, REORGANIZATION AND MERGER ACT

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83-31-173. Provisions applicable to mutual insurance holding companies; exemptions from certain provisions.
83-31-175. Actions challenging validity.
83-31-177. Mutual insurance holding company conversion to stock holding company.
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§ 83-31-101. Short title.

The provisions of Sections 83-31-101 through 83-31-181 may be cited as the "Mississippi Mutual Insurance Company Conversion, Reorganization and Merger Act."

HISTORY: Laws, 1998, ch. 576, § 1, eff from and after July 1, 1998.

Cross References — Domestic mutual insurance company merger with foreign mutual insurance company, see § 83-31-47.

Mutual insurance holding company provisions, see § 83-31-145 et seq.

Mutual insurance holding company conversion to stock holding company, see § 83-31-177.

§ 83-31-103. Definitions.

As used in Sections 83-31-101 through 83-31-143, the following terms shall have the meaning ascribed herein unless the context indicates otherwise:

(a) "Conversion plan" means a plan adopted under Sections 83-31-101 through 83-31-143 by the board of directors of a domestic mutual insurance company to convert the mutual insurance company into a stock company.

(b) "Converted stock company" means a domestic stock insurance company that has converted under Sections 83-31-101 through 83-31-143 from a domestic mutual insurance company.

(c) "Eligible member" means a member of a mutual insurance company whose policy is in force on the date that the mutual insurance company's board of directors adopts a conversion plan. The term does not include a person whose policy becomes effective after the date that the board of directors adopts the conversion plan but before the conversion plan's effective date.

(d) "Mutual insurance company" means a domestic mutual insurance company formed under Section 83-31-1 et seq. except for domestic mutual insurance companies that have active life insurance or annuities products in force.

(e) "Participating policy" means a policy that grants a holder the right to receive dividends or other distributions if, as and when, declared by the mutual insurance company that issued such policy.

(f) "Stock company" means a domestic stock insurance company subject to Section 83-19-1 et seq.

HISTORY: Laws, 1998, ch. 576, § 2, eff from and after July 1, 1998.

§ 83-31-105. Conversion plan adoption and approval.

(1) A mutual insurance company that seeks to convert to a stock company must adopt, by the affirmative vote of not less than two-thirds (⅔) of the members of its board of directors, a conversion plan consistent with the requirements of Sections 83-31-101 through 83-31-143. A mutual insurance company may not engage in the business of insurance as a stock company until it complies with the requirements of Sections 83-31-101 through 83-31-143.

(2) Before the eligible members of a mutual insurance company may vote on approval of a conversion plan, the mutual insurance company must comply with Section 83-31-107 and other applicable requirements under Sections 83-31-101 through 83-31-143.

HISTORY: Laws, 1998, ch. 576, § 3, eff from and after July 1, 1998.

Cross References — Alternative conversion plans, see § 83-31-127.

§ 83-31-107. Commissioner approval of conversion plan; public hearings.

(1) Not later than the ninetieth day after the date on which a mutual

insurance company's board of directors adopts a conversion plan, the company shall file with the commissioner:

(a) A copy of the conversion plan, including the documents relating to the conversion plan;

(b) The independent evaluation of a pro forma market value required by Section 83-31-121(2);

(c) The form of notice required by Section 83-31-111;

(d) The form of proxy to be solicited from eligible members under Section 83-31-113(2);

(e) The form of notice required by Section 83-31-129(3) to persons whose policies are issued after adoption of the conversion plan but before the effective date of the conversion plan;

(f) An audited financial statement prepared on a statutory basis in accordance with the insurance laws of the State of Mississippi, including an actuarial opinion for the most recent calendar year ended, or a copy thereof, if the statement was previously filed with the commissioner;

(g) The proposed amended or restated articles of association of the converted stock company, which shall include a change of the name of the company to delete the word "mutual" from the name of such company and proposed amended or restated bylaws of such company;

(h) A statement regarding acquisition of control, if applicable, as required by Section 83-6-1 et seq.; and

(i) Any other information as required under rules or regulations or as requested by the commissioner.

(2) Except as otherwise provided by this subsection, the commissioner shall approve or disapprove a conversion plan not later than the ninetieth day after the first day on which all the documents and other information required under subsection (1) of this section are filed with the commissioner. The commissioner may not extend the time for approval or disapproval beyond the ninety-day time period unless he finds it necessary to retain a qualified expert in accordance with subsection (4) of this section, in which case he may extend the time for review for an additional sixty (60) days beyond the initial ninety-day period. Notwithstanding the stated time limits herein, the commissioner may extend the time for approval or disapproval for an additional thirty (30) days beyond the date on which any amendment to such plan is filed with the commissioner. The commissioner shall, within five (5) days of approving or disapproving a conversion plan, give written notice to the mutual insurance company of the commissioner's decision and, in the event of disapproval, a detailed statement of the reasons for the adverse decision. If a plan is disapproved, then the conversion plan may be amended and resubmitted to the commissioner for his approval or disapproval as provided in Sections 83-31-101 through 83-31-143. If the commissioner disapproves the plan, then the mutual insurance company may appeal the commissioner's decision as provided by the laws of this state to the Chancery Court of the First Judicial District of Hinds County, Mississippi.

(3) The commissioner shall approve a conversion plan if the commissioner finds that the conversion plan complies with Sections 83-31-101 through

83-31-143, the conversion plan's method of allocating subscription rights or other value is fair and equitable and the conversion plan is otherwise fair and equitable to members and policyholders, and the converted stock company would satisfy the requirements applicable to a domestic stock company; however, the commissioner may not approve such a conversion plan and shall disapprove such a plan if the commissioner finds that (a) the effect of the conversion plan would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein; (b) the financial condition of any party to the conversion plan is such as might jeopardize the financial stability of the insurers which are parties to the plan or prejudice the interests of their policyholders; (c) the conversion plan or the plans for operation of the parties to the conversion plan following implementation of the conversion plan are not in the public interest; (d) the competence, experience and integrity of those persons who would control the operations of the parties to the conversion plan are such that it would not be in the interest of policyholders of the parties to the conversion plan or of the public to permit the conversion plan; (e) the conversion plan's method of allocating subscription rights or other value is not fair and equitable; (f) the conversion plan is not fair and equitable to the members and policyholders; (g) implementation of the conversion plan is likely to be hazardous or prejudicial to the insurance buying public; or (h) the conversion unfairly enriches the officers and directors of the converting insurer.

(4) The commissioner may retain, at the mutual insurance company's expense, a qualified expert or experts, including but not limited to appraisers, actuaries, accountants and attorneys, not otherwise a part of the commissioner's staff to assist the commissioner in reviewing the conversion plan and the independent evaluation of the pro forma market value required under Section 83-31-121(2).

(5) The commissioner may hold a public hearing to allow comment on the conversion plan after giving written notice to the mutual insurance company and other interested persons, all of whom have the right to appear at the hearing. Notice to interested persons who have not filed an appearance in the matter may be made in any reasonable manner deemed appropriate by the commissioner with the costs thereof assessed to the mutual insurance company.

HISTORY: Laws, 1998, ch. 576, § 4, eff from and after July 1, 1998.

Cross References — Requirements for conversion plan to take effect, see § 83-31-129.

§ 83-31-109. Notice to eligible members and comments; amendment and termination of plan.

(1) The conversion plan may be:

(a) Amended by a vote of two-thirds (⅔) of the members of the board of directors of the applicant in response to the comments or recommendations of the commissioner or any other state or federal agency or governmental entity before any solicitation of proxies from members of the mutual insurance company to vote on the conversion plan or at any time with the consent of the commissioner, except that any material amendment after the members' approval shall require the members' approval; or

(b) Terminated by a vote of two-thirds (⅔) of the members of the board of directors of the applicant at any time before members of the mutual insurance company vote on the conversion plan and, otherwise, at any time with the consent of the commissioner.

(2)(a) Within twenty (20) business days after filing with the commissioner the documents required under Section 83-31-107(1), the mutual insurance company shall send to each eligible member a notice advising the eligible member of the adoption and filing of the conversion plan and of the member's right to provide to the commissioner and the mutual insurance company comments on the plan.

(b) As an alternative to the notice required under paragraph (a) of this subsection, the mutual insurance company may use any other means which is reasonably designed to provide notice to eligible members and which alternative means of providing notice is approved by the commissioner.

(c) The notice required under paragraphs (a) or (b) of this subsection shall include a description of the procedure to be used in making comments.

(3) An eligible member who elects to make comments must make the comments in writing (a) if notice is sent to each eligible member, not later than the thirtieth day after the date on which the notice is sent; or (b) if an alternative means of providing notice is approved by the commissioner, not later than such date for receipt of comments approved by the commissioner.

HISTORY: Laws, 1998, ch. 576, § 5, eff from and after July 1, 1998.

Cross References — Good faith failure to provide notice required by this section, see § 83-31-135.

§ 83-31-111. Member meeting notice for voting on conversion plan.

(1) Within sixty (60) days after the commissioner's approval of the plan, the mutual insurance company shall send to each eligible member notice of the members' meeting to vote on the conversion plan. The notice must be sent to the member's last known address, as shown on the mutual insurance company's records, before the thirtieth day preceding the date set for the meeting. The notice shall:

(a) Briefly but fairly describe the material terms and provisions of the proposed conversion plan; and

(b) Inform the member of the member's right to vote on the conversion plan.

(2) If the meeting to vote on the conversion plan is held during the mutual insurance company's annual meeting of policyholders, only a combined meeting notice is required.

HISTORY: Laws, 1998, ch. 576, § 6, eff from and after July 1, 1998.

Cross References — Good faith failure to provide notice required by this section, see § 83-31-135.

§ 83-31-113. Member votes on plan and amending or restating articles of association.

(1) A conversion plan is adopted on receiving the affirmative vote of at least two-thirds (⅔) of the votes cast in person or by proxy by eligible members at a duly convened meeting to consider the plan of conversion.

(2) Members entitled to vote on the proposed conversion plan may vote in person or by proxy. The number of votes each eligible member may cast shall be determined by the mutual insurance company's bylaws. If the bylaws are silent, each eligible member may cast one (1) vote.

(3) At the meeting held to vote on the conversion plan, the members shall also consider the adoption of amended or restated articles of association. Adoption of the amended or restated articles requires the affirmative vote of at least two-thirds (⅔) of the votes cast in person or by proxy by eligible members.

HISTORY: Laws, 1998, ch. 576, § 7, eff from and after July 1, 1998.

§ 83-31-115. Filing minutes concerning member plan adoption meeting.

Not later than the thirtieth day after the date on which the eligible members adopt the conversion plan at a duly convened meeting, the converted stock company shall file with the commissioner the minutes of the meeting of the eligible members at which the conversion plan was adopted.

HISTORY: Laws, 1998, ch. 576, § 8, eff from and after July 1, 1998.

§ 83-31-117. Conversion plan requirements; effect on existing policies; nonparticipating policies.

(1) Each conversion plan must include the provisions required by Sections 83-31-101 through 83-31-143 and by any rules or regulations adopted by the commissioner.

(2) Each policy in effect on the effective date of the conversion remains in effect under the terms of that policy, except that the following rights, to the extent they existed in the mutual insurance company, are extinguished on the effective date of the conversion:

(a) Any voting rights of policyholders provided under the policy;

(b) Except as provided in subsection (3) of this section, a right to share in the surplus or profits of the mutual insurance company; and

(c) Any assessment provisions provided under the policy.

(3) Except as otherwise provided by Section 83-31-143, the holder of a participating policy in effect on the date of the conversion continues to have a

right to receive dividends or distributions as provided by the participating policy.

(4) Except for the mutual insurance company's guaranteed renewable accident and health policies and guaranteed renewable, noncancellable accident and health policies, on the renewal date of a participating policy, the converted stock company may issue the insured a nonparticipating policy as a substitute for the participating policy on such terms and conditions and on such policy forms as shall be approved by the commissioner.

HISTORY: Laws, 1998, ch. 576, § 9, eff from and after July 1, 1998.

§ 83-31-119. Subscription rights and alternatives.

(1) Except for an alternative plan under Section 83-31-127, each conversion plan must specify the subscription rights of eligible members.

(2) The plan must include a provision that:

(a) Each eligible member is to receive, without payment by the member, nontransferable subscription rights to purchase a portion of the capital stock of the converted stock company, including a method for determining the number of shares which may be purchased; and

(b) In the aggregate, all eligible members have the right, before the right of any other party, to purchase one hundred percent (100%) of the capital stock of the converted stock company; however, that such plan may provide for the sale or distribution of capital stock to the holders of surplus notes, if any, but only upon such terms and conditions as may be approved by the commissioner.

(3) As an alternative to subscription rights in the converted stock company, the conversion plan may provide that each eligible member is to receive, without payment by the member, nontransferable subscription rights to purchase a portion of the capital stock of one of the following:

(a) A corporation organized for the purpose of purchasing and holding all the stock of the converted stock company;

(b) A stock insurance company owned by the mutual insurance company into which the mutual insurance company is to be merged; or

(c) An unaffiliated stock insurance company or other corporation that is to purchase all the stock of the converted stock company.

(4) The conversion plan must provide that the subscription rights are allocated in whole shares among the eligible members using a fair and equitable method, with such exceptions and other terms and conditions as the commissioner may approve. The method may consider, but is not required to consider, how the different classes of policies of the eligible members contributed to the surplus of the mutual insurance company or any other factors that may be fair or equitable as determined by the board of directors.

(5) The conversion plan must provide a fair and equitable means for allocating shares of capital stock in the event of an oversubscription to shares by eligible members exercising subscription rights under this section.

(6) Notwithstanding any other provision of Section 83-31-47 or 83-31-101 through 83-31-181 to the contrary, no officer, director or employee of any

insurer reorganizing under any provision of Section 83-31-47 or 83-31-101 through 83-31-181 shall be eligible to receive subscription rights to, purchase or acquire any stock in the reorganized stock insurance company under any plan except in accordance with his rights as an eligible member, and then he shall receive only such rights as are received by other similarly situated eligible members.

HISTORY: Laws, 1998, ch. 576, § 10, eff from and after July 1, 1998.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section 83-31-47 or 83-31-101 through 83-31-181" for "Sections 83-31-47 or 83-31-101 through 83-31-181" twice in (6). The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-31-121. Capital stock sales and restrictions.

(1) The conversion plan must provide that any shares of capital stock not sold or distributed to holders of surplus notes, or subscribed to by eligible members exercising subscription rights under Section 83-31-119, may be sold in a private placement, public offering or other alternative method approved by the commissioner.

(2) The conversion plan must set the total price of the capital stock in an amount equal to the estimated pro forma market value of the converted stock company based on an independent valuation by a qualified expert, giving consideration to the amount of capital deemed necessary by the board of directors to be raised by the company. The pro forma market value may be the value estimated to be necessary to attract full subscription for the shares, as indicated by the independent valuation, and may be stated as a range of values.

(3) The conversion plan shall set the purchase price per share of capital stock at any reasonable amount approved by the commissioner. The purchase price per share need not be the same for each class of purchaser; however, eligible members purchasing stock in accordance with subscription rights received under Section 83-31-119 shall have the right to purchase shares at the lowest available purchase price under the plan.

(4) The conversion plan must provide that a person or group of persons acting in concert may not acquire, in the public offering or private placement or through the exercise of subscription rights, more than ten percent (10%) of the capital stock of the converted stock company except with the approval of the commissioner. This limitation does not apply to an entity that purchases one hundred percent (100%) of the capital stock of the converted company as part of the conversion plan approved by the commissioner.

HISTORY: Laws, 1998, ch. 576, § 11, eff from and after July 1, 1998.

§ 83-31-125. Liquidation account to be created.

The conversion plan may provide for the creation of a liquidation account for the benefit of members in the event of voluntary liquidation after conversion in an amount equal to the surplus of the mutual insurance company, exclusive of the principal amount of any surplus note, on the last day of the quarter immediately preceding the date of adoption of the conversion plan.

HISTORY: Laws, 1998, ch. 576, § 12, eff from and after July 1, 1998.

§ 83-31-127. Alternative conversion plans that do not rely on nontransferable subscription rights.

(1) The board of directors may adopt a conversion plan that does not rely wholly or partially on issuing nontransferable subscription rights to members to purchase stock of the converted stock company if the commissioner finds that the alternative conversion plan complies with Section 83-31-107(3).

(2) An alternative conversion plan may:

(a) Include the merger of a domestic mutual insurance company into a domestic or foreign stock insurance company;

(b) Provide for issuing stock, cash, or other consideration to members instead of subscription rights;

(c) Provide for the formation of a mutual holding company under Section 83-31-145 et seq.; or

(d) Set forth another plan containing any other provisions approved by the commissioner.

(3) The commissioner may retain, at the mutual insurance company's expense, a qualified expert or experts, including but not limited to appraisers, actuaries, accountants and attorneys, not otherwise a part of the commissioner's staff to assist in reviewing whether the alternative conversion plan may be approved by the commissioner.

HISTORY: Laws, 1998, ch. 576, § 13, eff from and after July 1, 1998.

§ 83-31-129. Requirements for conversion plan to take effect; member rights.

(1) For a conversion plan to take effect:

(a) The commissioner must approve the conversion plan; and

(b) The eligible members must approve the conversion plan and adopt the amended or restated articles of association.

(2) A conversion plan takes effect when the amended or restated articles of association are filed with and approved by the commissioner and also filed with the Mississippi Secretary of State or at such other delayed effective time and date as specified in the amended or restated articles of association as filed.

(3)(a) On issuance of a policy after a conversion plan has been adopted by the board of directors but before the effective date of the conversion plan, the mutual insurance company shall send to the member to whom the policy is issued a written notice regarding the conversion plan.

(b) Except as provided by paragraph (d) of this subsection, a member of an accident and health insurance company entitled to receive the notice described by paragraph (a) of this subsection is entitled to rescind the member's policy and receive a full refund of any amount paid for the policy not later than the ten (10) days after the date on which the member receives the notice.

(c) Except as provided by paragraph (d) of this subsection, each member who is insured under a property or casualty insurance policy is entitled to receive the notice provided by paragraph (a) of this subsection and shall be advised of the member's right to cancel the policy and receive a pro rata refund of unearned premiums.

(d) A member who has made or filed a claim under the insurance policy is not entitled to a right to receive a refund under paragraph (b) or (c) of this subsection. A person who has exercised the rights provided by paragraph (b) or (c) of this subsection is not entitled to make or file a claim under the insurance policy.

HISTORY: Laws, 1998, ch. 576, § 14, eff from and after July 1, 1998.

§ 83-31-131. Results on plan effective date.

(1) On the effective date of the conversion:

(a) The corporate existence of the mutual insurance company continues in the converted stock company; and

(b) All assets, rights, franchises and interests of the mutual insurance company in and to property, real, personal or mixed, and any accompanying things in action, are vested in the converted stock company, without a deed or transfer, and the converted stock company assumes all the obligations and liabilities of the mutual insurance company.

(2) Unless otherwise specified in the conversion plan, the directors and officers of the mutual insurance company serving on the effective date of the conversion serve as directors and officers of the converted stock company until new directors and officers of the converted stock company are elected under the articles of association and bylaws of the converted stock company.

HISTORY: Laws, 1998, ch. 576, § 15, eff from and after July 1, 1998.

§ 83-31-133. Fees, costs and expenses.

(1) A director, officer, agent or employee of the mutual insurance company may not receive a fee, commission or other consideration, other than that person's usual salary or compensation, for aiding, promoting or assisting in a conversion under Sections 83-31-101 through 83-31-143, except as provided by the conversion plan approved by the commissioner.

(2) All the costs and expenses connected with a conversion plan shall be paid for or reimbursed by the mutual insurance company or the converted stock company.

HISTORY: Laws, 1998, ch. 576, § 16, eff from and after July 1, 1998.

§ 83-31-135. Good faith failure to provide notice.

If the mutual insurance company complies substantially and in good faith with the notice requirements of Section 83-31-47 or 83-31-101 through 83-31-181, the mutual insurance company's failure to send a member the required notice under Section 83-31-109(2)(a) or Section 83-31-111(1) does not impair the validity of any action taken under Section 83-31-47 or 83-31-101 through 83-31-181.

HISTORY: Laws, 1998, ch. 576, § 17, eff from and after July 1, 1998.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section 83-31-47 or 83-31-101 through 83-31-181" for "Sections 83-31-47 or 83-31-101 through 83-31-181" twice in this section. The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-31-137. Actions challenging validity.

An action challenging the validity of or arising out of acts taken or proposed to be taken regarding a conversion plan under Sections 83-31-101 through 83-31-143 must begin in the Chancery Court of the First Judicial District of Hinds County, Mississippi, not later than the thirtieth day after the effective date of the conversion plan.

HISTORY: Laws, 1998, ch. 576, § 18, eff from and after July 1, 1998.

§ 83-31-139. Insolvent companies or companies in financially hazardous condition; waiver.

(1) If a mutual insurance company is insolvent or, in the judgment of the commissioner, is in hazardous financial condition, its board of directors, by a majority vote, may petition the commissioner to waive the provisions of Sections 83-31-101 through 83-31-143 requiring notice to and policyholder approval of the planned conversion.

(2) The petition must specify the method and basis for the issuance of the converted stock company's shares of its capital stock to an independent party in connection with an investment by the independent party in an amount sufficient to restore the converted stock company to a sound financial condition.

(3) The conversion may be accomplished without payment of consideration to past, present or future policyholders, but only if the petition makes such a specific request and the commissioner finds that the value of the mutual insurance company is insufficient to warrant that consideration.

HISTORY: Laws, 1998, ch. 576, § 19, eff from and after July 1, 1998.

§ 83-31-141. Requirements for acquiring control; converted company rights, privileges and compliance.

(1) A mutual insurance company may not be permitted to convert under

Sections 83-31-101 through 83-31-143 if, as a direct result of the conversion, any person or any affiliate acquires control of the converted stock company, unless that person or the affiliate complies with the requirements of Section 83-6-1 et seq.

(2) Except as otherwise specified in Section 83-31-47 or 83-31-101 through 83-31-181, a converted stock company has all of the rights and privileges and is subject to all of the requirements and regulations imposed on stock companies formed under the laws of this state but may not exercise rights or privileges that other stock companies may not exercise.

HISTORY: Laws, 1998, ch. 576, § 20, eff from and after July 1, 1998.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section 83-31-47 or 83-31-101 through 83-31-181" for "Sections 83-31-47 or 83-31-101 through 83-31-181" near the beginning of (2). The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-31-143. Endorsement or rider extinguishing policy rights.

A mutual insurance company, by endorsement or rider approved by the commissioner and delivered to the policyholder, may simultaneously with or at any time after the adoption of a conversion plan amend any outstanding insurance policy to evidence the extinguishment of the rights, if any, of the holder of the policy as described in the plan of conversion approved by the commissioner. However, such an amendment is void if the conversion plan does not take effect.

HISTORY: Laws, 1998, ch. 576, § 21, eff from and after July 1, 1998.

§ 83-31-145. Definitions applicable to mutual insurance holding company provisions.

As used in Sections 83-31-145 through 83-31-181, the following items shall have the meaning ascribed herein unless the context indicates otherwise:

(a) "Mutual insurance holding company" means an incorporated entity without permanent capital stock that is organized under Section 83-31-145 et seq. and whose members are determined in accordance with such provisions.

(b) "Subsidiary insurance company" means a stock insurance company, the majority of the voting shares of the capital stock of which are at all times owned by a mutual insurance holding company. For these purposes, "majority of the voting shares of the capital stock" means shares of the capital stock of a company which carry the right to cast a majority of the votes entitled to be cast by all of the outstanding shares of the capital stock for the election of directors, other than securities having voting power only because of the occurrence of a contingency. The ownership of a majority of the voting shares of the capital stock of a former mutual insurance company reorganized under Sections 83-31-145 through 83-31-181 which voting shares are required by Sections 83-31-145 through 83-31-181 to be at all times owned by a mutual insurance holding company includes indirect ownership through one or more intermediate holding companies. However, indirect ownership through one or more intermediate holding companies shall not result in a mutual insurance holding company owning less than the equivalent of a majority of the voting shares of the capital stock of the former mutual reorganized insurance company.

(c) "Intermediate holding company" means a holding company which is a subsidiary of a mutual insurance holding company and which directly or through a subsidiary intermediate holding company owns a majority of the voting shares of the capital stock of one or more subsidiary insurance companies.

(d) "Plan of reorganization" means a plan adopted under Sections 83-31-145 through 83-31-181 by the board of directors of a domestic mutual insurance company to reorganize as provided in Section 83-31-151.

(e) "Mutual insurance company" means a domestic mutual insurance company formed pursuant to Section 83-31-1 et seq. except for domestic mutual insurance companies that have active life insurance or annuities products in force.

HISTORY: Laws, 1998, ch. 576, § 22, eff from and after July 1, 1998.

§ 83-31-147. Holding company voting share ownership; securities issuance.

(1) The voting shares of the capital stock of a subsidiary insurance company, which are required by Sections 83-31-145 through 83-31-181 in order to maintain a majority of the voting shares, are to be at all times owned by a mutual insurance holding company or one or more intermediate holding companies and the voting shares of the capital stock of any intermediate holding company, which are necessary to satisfy such ownership requirement through indirect ownership, shall not be conveyed, transferred, assigned, pledged, subjected to a security interest or lien, encumbered or otherwise hypothecated or alienated by the mutual insurance holding company or any intermediate holding company, except with the prior approval of the commissioner. Any conveyance, transfer, assignment, pledge, security interest, lien, encumbrance or hypothecation or alienation of, in or on such voting shares of capital stock is in violation of this section and shall be void in inverse chronological order of the date of such conveyance, transfer, assignment, pledge, security interest, lien, encumbrance or hypothecation or alienation as to such shares of capital stock. The shares of the capital stock of the surviving or new company resulting from a merger or consolidation of two (2) or more subsidiary insurance companies or two (2) or more intermediate holding companies which were subsidiaries of the same mutual insurance holding company are subject to the same requirements, restrictions, and limitations as provided in this section to which the shares of the merging or consolidating

former mutual reorganized insurance companies or intermediate holding companies were subject by this section before the merger or consolidation.

(2) Upon approval of the commissioner and compliance with applicable law, an intermediate holding company or a subsidiary insurance company may issue to the mutual insurance holding company and to other persons securities, including voting stock, nonvoting stock and securities convertible into voting or nonvoting stock, if, after giving effect to such issuance, in the aggregate, the issued and outstanding voting stock of the intermediate holding company or the subsidiary insurance company held directly or indirectly by the mutual insurance holding company is not less than a majority of the voting shares of capital stock of such intermediate holding company or subsidiary insurance company. For purposes of this limitation, any issued and outstanding securities of an intermediate holding company or subsidiary insurance company that are convertible into voting stock shall be considered issued and outstanding voting stock. Upon approval of the commissioner and compliance with applicable law, an intermediate holding company or a subsidiary insurance company may issue any such securities: (a) to policyholders of a subsidiary insurance company in accordance with a subscription offering containing such terms, conditions and limitations as are approved by the board of directors of such intermediate holding company or subsidiary insurance company and the mutual insurance holding company; (b) in a public offering; or (c) in a private placement, including, without limitation, to one or more purchasers who are holders of surplus notes or other securities of a subsidiary insurance company, have or will have a lending, pooling or reinsurance arrangement with a subsidiary insurance company, have or will have an insurance, marketing, investment, support or other cooperative arrangement or affiliation with the subsidiary insurance company or are an affiliate of any entity which has such a relationship.

HISTORY: Laws, 1998, ch. 576, § 23, eff from and after July 1, 1998.

§ 83-31-149. Domestic mutual insurance holding company powers and compliance with nonprofit private corporation provisions.

Domestic mutual insurance holding companies shall have all the powers and authority and shall be subject to the requirements applicable to Mississippi nonprofit private corporations under Section 79-11-101 et seq., except:

(a) A mutual insurance holding company shall be organized exclusively under Sections 83-31-145 through 83-31-181 and shall be a mutual company without capital stock.

(b) The articles of association of the mutual insurance holding company and any amendment to such articles or restatement of such articles shall be subject to the approval of the commissioner for compliance with the provisions of Sections 83-31-145 through 83-31-181 before filing with the Mississippi Secretary of State and shall contain the name of the mutual insurance holding company, which shall include the word "mutual."

(c) To the extent that the provisions of Section 79-11-101 et seq. conflict with the provisions of Section 83-31-47 or 83-31-101 through 83-31-181, the insurance laws of the State of Mississippi or the regulations of the commissioner, then such provisions of Section 83-31-47 or 83-31-101 through 83-31-181, the insurance laws of the State of Mississippi or the regulations of the commissioner shall control.

HISTORY: Laws, 1998, ch. 576, § 24, eff from and after July 1, 1998.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section 83-31-47 or 83-31-101 through 83-31-181" for "Sections 83-31-47 or 83-31-101 through 83-31-181" twice in (c). The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-31-151. Reorganization and subsidiaries.

(1) A domestic mutual insurance company, by itself or together with one or more other mutual insurance companies, under a plan of reorganization, may reorganize as a mutual insurance holding company system that must consist of a mutual insurance holding company and one or more controlled subsidiaries and which may consist of one or more intermediate stock holding companies and other subsidiaries as permitted by Section 83-6-1 et seq. The reorganization may be effected by the organization of one or more companies, amendment or restatement of the articles of association and bylaws of one or more companies, transfer of assets and liabilities among two (2) or more companies, issuance, acquisition or transfer of capital stock of one or more companies or merger or consolidation of two (2) or more companies. On and after the effective date of a plan of reorganization, the mutual insurance holding company shall at all times own, directly or indirectly, a majority of the voting shares of each controlled subsidiary and any intermediate stock holding company.

(2) All of the initial shares of the capital stock of the insurance company which reorganized as a subsidiary insurance company shall be issued either to the mutual insurance holding company or to an intermediate holding company which is wholly owned by the mutual insurance holding company. This restriction does not preclude the subsequent issuance of additional shares of stock by an intermediate holding company or the subsidiary insurance company, subject to the approval of the commissioner and compliance with applicable law, so long as the mutual insurance holding company at all times owns directly or through one or more intermediate holding companies, a majority of the voting shares of the capital stock of the subsidiary insurance company. The membership interests of the policyholders of the subsidiary insurance company shall become membership interests in the mutual insurance holding company in accordance with the plan of reorganization. Policyholders of the subsidiary insurance company which was formerly the mutual insurer shall be members of the mutual insurance holding company in accordance with the plan of reorganization and the articles of association and bylaws of the mutual insurance holding company.

HISTORY: Laws, 1998, ch. 576, § 25, eff from and after July 1, 1998.

§ 83-31-153. Reorganization plan requirements; adoption and approval.

(1) A plan of reorganization shall include the following provisions:

(a) A description of the structure of the proposed mutual insurance holding company system consistent with the requirements therefor set forth in Sections 83-31-145 through 83-31-181.

(b) A description of the qualifications for membership in and the rights of members of the mutual insurance holding company consistent with the requirements therefor set forth in Sections 83-31-145 through 83-31-181, provisions for the extinguishment of membership interests in the mutual insurance company and provisions for the conversion of such membership interests in the mutual insurance company into membership interests in the mutual insurance holding company.

(c) A description of the transactions, and parties to such transactions, that will effect the reorganization, including, but not limited to, transfer and assumption of policies, contracts, assets and liabilities.

(d) A description of corporate restructuring and other corporate transactions that will effect the reorganization, including, but not limited to, formation or organization of companies, amendment or restatement of articles of association or bylaws or those proposed in connection with the formation or organization of companies in connection with the plan and mergers and consolidations.

(e) A description of those persons who shall serve as directors and officers of the mutual insurance holding company, its intermediate stock holding companies, if any, its controlled subsidiaries and other subsidiaries as of the effective date of the reorganization. The initial directors of each such company shall be the directors of the mutual insurance company who shall have terms concurrent with the terms as directors of the reorganized mutual insurance company unless otherwise specified in the plan.

(f) Provisions requiring that, following the reorganization, the material terms and conditions of indemnification or coverage of policyholders of the mutual insurance company shall remain in full force and effect under policies transferred to and assumed by one or more subsidiaries of the mutual insurance holding company.

(g) Provisions requiring that, following the reorganization, the material terms and conditions of subordinated surplus notes and other contractual obligations, other than those arising under policies described in paragraph (f) of this subsection (1), of the mutual insurance company, subject to the rights of the mutual insurance company under applicable law, and to the extent such obligations are not otherwise satisfied or terminated in accordance with their terms or retained by a mutual insurance holding company or controlled subsidiary, shall remain in full force and effect upon the transfer of such obligations to, and assumption of such obligations by, one or more subsidiaries of the mutual insurance holding company.

(2) A plan of reorganization must be adopted by two-thirds (⅔) of the members of the board of directors of the mutual insurance company or, in the case of the formation of any intermediate stock insurance holding company that is not concurrent with the formation of the mutual insurance holding company, by two-thirds (⅔) of the members of the board of directors of the mutual insurance holding company.

(3) Not later than the ninetieth day following the adoption of a plan of reorganization by the board of directors, and before the meeting of the mutual insurance company members to approve the plan, the mutual insurance company shall submit to the commissioner the following:

(a) The plan of reorganization, as adopted.

(b) The form of notice to be sent to the mutual insurance company members, informing them of their right to vote on the plan of reorganization.

(c) The form of proxy statement to be sent to the mutual insurance company members informing them of their right to vote by proxy on the plan of reorganization and describing the plan.

(d) The form of proxy to be sent to the mutual insurance company members to solicit their vote on the plan of reorganization.

(e) Proposed articles of association, merger or consolidation, bylaws, restatements of or amendments to articles of association and bylaws and plans of merger or consolidation with respect to each entity to be organized, reorganized or otherwise subject to such action under the plan of reorganization.

(f) An audited financial statement prepared on a statutory basis in accordance with the insurance laws of the State of Mississippi, including an actuarial opinion for the most recent calendar year ended, or a copy thereof, if the statement was previously filed with the commissioner.

(g) Such other information as required under rules or regulations or as requested by the commissioner.

(4) The commissioner may hold a public hearing to allow public comment on the plan of reorganization after giving written notice to the mutual insurance company and other interested persons, all of whom have the right to appear at the hearing. Notice to interested persons who have not filed an appearance in the matter may be made in any reasonable manner deemed appropriate by the commissioner with the costs thereof assessed to the mutual insurance company.

(5)(a) Within twenty (20) business days after filing with the commissioner the documents required in connection with a plan of reorganization, the mutual insurance company shall send to each eligible member a notice advising the eligible member of the adoption and filing of the plan of reorganization and of the member's right to provide to the commissioner and the mutual insurance company comments on the plan.

(b) As an alternative to the notice required under paragraph (a) of this subsection, the mutual insurance company may use any other means which is reasonably designed to provide notice to eligible members and which alternative means of providing notice is approved by the commissioner.

(c) The notice required under paragraph (a) or (b) of this subsection shall include a description of the procedure to be used in making comments.

(d) An eligible member who elects to make comments must make the comments in writing (i) if notice is sent to each eligible member, not later than the thirtieth day after the date on which the notice is sent, or (ii) if an alternative means of providing notice is approved by the commissioner, not later than such date for receipt of comments approved by the commissioner.

(6) Except as otherwise provided by this subsection, the commissioner shall approve or disapprove a plan of reorganization not later than the ninetieth day after the first day on which all the documents and other information required are filed with the commissioner. The commissioner may not extend the time for approval or disapproval beyond the ninety-day time period unless he finds it necessary to retain a qualified expert in accordance with subsection (7) of this section, in which case he may extend the time for review for an additional sixty (60) days beyond the initial ninety-day period. Notwithstanding the stated time limits herein, the commissioner may extend the time for approval or disapproval for an additional thirty (30) days beyond the date on which any amendment to such plan is filed with the commissioner. The commissioner shall, within five (5) days of approving or disapproving a plan of reorganization, give written notice to the mutual insurance company of the commissioner's decision and, in the event of disapproval, a detailed statement of the reasons for the adverse decision. If a plan is disapproved, then the plan of reorganization may be amended and resubmitted to the commissioner for his approval or disapproval as provided in Sections 83-31-145 through 83-31-181. If the commissioner disapproves the plan then the mutual insurance company may appeal the commissioner's decision as provided by the laws of this state to the Chancery Court of the First Judicial District of Hinds County, Mississippi.

(7) The commissioner may retain, at the mutual insurance company's expense, a qualified expert or experts, including but not limited to appraisers, actuaries, accountants and attorneys, not otherwise a part of the commissioner's staff to assist the commissioner in reviewing the plan of reorganization.

(8) The commissioner shall approve a plan of reorganization if the commissioner finds that the plan of reorganization complies with Sections 83-31-145 through 83-31-181 and the plan of reorganization is fair and equitable to members and policyholders; however, the commissioner may not approve such a plan of reorganization and shall disapprove such a plan if the commissioner finds that (a) the effect of the plan of reorganization would be substantially to lessen competition in insurance in this state or tend to create a monopoly therein; (b) the financial condition of any party to the plan of reorganization is such as might jeopardize the financial stability of the insurers which are parties to the plan, or prejudice the interests of their policyholders; (c) the plan of reorganization or the plans for operation of the parties to the plan of reorganization following implementation of the plan of reorganization are not in the public interest; (d) the competence, experience and integrity of those persons who would control the operations of the parties

to the plan of reorganization are such that it would not be in the interest of policyholders of the parties to the plan of reorganization or of the public to permit the plan of reorganization; (e) the plan of reorganization's method of allocating value is not fair and equitable; (f) the plan of reorganization is not fair and equitable to the members and policyholders; (g) implementation of the plan of reorganization is likely to be hazardous or prejudicial to the insurance buying public; or (h) the plan of reorganization unfairly enriches the officers and directors of the reorganizing insurer.

(9)(a) A plan of reorganization adopted by the board of directors of the mutual insurance company may be:

(i) Amended by the board of directors of the mutual insurance company in response to the comments or recommendations of the commissioner or any other state or federal agency or governmental entity before any solicitation of proxies from members of the mutual insurance company to vote on the plan of reorganization or at any time with the consent of the commissioner, except that any material amendment after the members' approval shall require the members' approval; or

(ii) Terminated by the board of directors of the applicant at any time before members of the mutual insurance company vote on the plan of reorganization and, otherwise, at any time with the consent of the commissioner.

(b) The plan of reorganization is approved upon the affirmative vote of at least two-thirds (⅔) of the votes cast by members of the mutual insurance company, notwithstanding quorum or voting action requirements otherwise applicable to the mutual insurance company to the contrary.

(c) Within thirty (30) days after members have approved the plan of reorganization, the applicant must file with the commissioner the minutes of the meeting at which the plan of reorganization was approved.

HISTORY: Laws, 1998, ch. 576, § 26, eff from and after July 1, 1998.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "paragraph (f) of this subsection (1)" for "paragraph (f) of this section" in (1)(g). The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-31-155. Dividends and distributions to members.

A mutual insurance holding company shall not be authorized to pay dividends or make distributions to mutual insurance holding company members except as may be expressly approved by the commissioner. Neither the adoption nor the implementation of a plan of reorganization leading to the formation of a mutual holding company shall be deemed to give rise to any obligation by or on behalf of a mutual insurance company to make any distribution or payment to any member or policyholder or to any other person, fund or entity of any nature whatsoever in connection with the ownership, control, benefits, policies, purpose, or nature of the mutual insurance company or otherwise.

HISTORY: Laws, 1998, ch. 576, § 27, eff from and after July 1, 1998.

§ 83-31-157. Holding company merger or consolidation.

(1) Subject to applicable requirements of Sections 83-31-47 and 83-31-101 through 83-31-181 and Section 83-6-1 et seq., a mutual insurance holding company may:

(a) Merge or consolidate with, or acquire the assets of, a mutual insurance holding company formed under Section 83-31-47 or 83-31-101 through 83-31-181 or any similar entity or organization formed under the laws of any other state;

(b) Either alone or together with one or more intermediate stock holding companies, or other subsidiaries, directly or indirectly acquire the stock of a stock insurance company or a mutual insurance company that reorganizes under Section 83-31-47 or 83-31-101 through 83-31-181 or the law of its state of organization;

(c) Together with one or more of its stock insurance company subsidiaries, acquire the assets of a stock insurance company or a mutual insurance company;

(d) Acquire a stock insurance company through the merger of such stock insurance subsidiary with a stock insurance company or intermediate stock insurance company subsidiary of the mutual insurance holding company; or

(e) Acquire the stock or assets of any other person to the same extent as would be permitted for a mutual insurance company.

(2)(a) A plan and agreement for merger or consolidation in accordance with subsection (1) of this section shall be submitted to and approved by two-thirds (⅔) of the members of each domestic mutual insurance holding company or mutual insurance company involved in the merger or consolidation who vote either in person or by proxy thereon at meetings called for the purposes pursuant to such reasonable notice and procedure as has been approved by the commissioner; however, no vote of a domestic mutual insurance holding company shall be required to approve the merger of a mutual insurance holding company which has resulted from the reorganization of a domestic or foreign mutual insurance company and which has surplus equal to not more than twenty-five percent (25%) of the surplus of the combined companies.

(b) No such merger or consolidation shall be effectuated unless in advance thereof the plan and agreement therefor have been filed with the commissioner and approved by the commissioner in accordance with Section 83-6-1 et seq.

(c) All of the initial shares of the capital stock of the reorganized subsidiary insurance company shall be issued either to the mutual insurance holding company, or to an intermediate holding company which is a subsidiary of the mutual insurance holding company. The membership interests of the policyholders of the reorganized insurance company shall become membership interests in the mutual insurance holding company in accordance with the plan and agreement of merger or consolidation. Policyholders of the reorganized insurance company shall be members of the mutual insurance holding company in accordance with the plan and agreement of merger or consolidation and the articles of association and bylaws of the mutual insurance holding company. The mutual insurance holding company shall at all times directly or indirectly own a majority of the voting shares of the capital stock of any reorganized subsidiary insurance company.

HISTORY: Laws, 1998, ch. 576, § 28, eff from and after July 1, 1998.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section 83-31-47 or 83-31-101 through 83-31-181" for "Sections 83-31-47 or 83-31-101 through 83-31-181" in (1)(a) and (1)(b). The Joint Committee ratified the correction at its August 10, 2022, meeting.

Cross References — Mutual insurance holding company investments, see § 83-31-167.

§ 83-31-159. Filing and approval of articles of association.

(1) No mutual insurance holding company shall be formed unless its articles of association are approved by the commissioner before filing the articles of association with the Mississippi Secretary of State as provided by law.

(2) The articles of association shall be effective when filed with and approved by the commissioner and also filed with the Mississippi Secretary of State or at such other delayed effective time and date as specified in the articles of association as filed.

HISTORY: Laws, 1998, ch. 576, § 29, eff from and after July 1, 1998.

§ 83-31-161. Amending articles of association.

(1) A domestic mutual insurance holding company may amend its articles of association by vote of a majority of those members present or represented by proxy at a lawful meeting of its members if the notice given members included due notice of the proposal to amend.

(2) Upon adoption of an amendment, the articles of amendment shall be effective when filed with and approved by the commissioner and also filed with the Mississippi Secretary of State or at such other delayed effective time and date as specified in the articles of amendment.

HISTORY: Laws, 1998, ch. 576, § 30, eff from and after July 1, 1998.

§ 83-31-163. Bylaws.

(1) The initial board of directors of a mutual insurance holding company shall adopt bylaws.

(2) The bylaws shall provide:

(a) That each member is entitled to one (1) vote upon each matter coming to a vote at meetings of members or to more votes in accordance with a reasonable classification of members as set forth in the bylaws and based upon the amount of insurance in force with the mutual insurance holding company's subsidiaries or upon the amount of the premiums paid to the mutual insurance holding company's subsidiaries by such member or upon other reasonable factors. The bylaws shall provide that a member has the right to vote in person or by his written proxy. The bylaws may specify the mode of voting by proxy and other requirements relating to voting by proxy consistent with procedures used by mutual insurance companies in accordance with Section 83-31-9 et seq.

(b) For the election of directors by the members and the number, qualifications, terms of office, subject to the requirements of Section 83-31-165.

(c) For the time, notice and conduct of annual and special meetings of members and voting thereat.

(d) For the number, designation, election, terms and powers and duties of the respective corporate officers.

(e) For deposit, custody and disbursement of and accounting for corporate funds.

(f) That a quorum at all annual and special meetings of members shall consist of all members present and voting in person or by proxy, after due notice of such meeting.

(g) For any other reasonable provisions customary, necessary or convenient for the management or regulation of the company's corporate affairs not inconsistent with law.

(3) Within thirty (30) days of adoption of any bylaws or any modification thereof or addition thereto, a mutual insurance holding company shall file with the commissioner a copy, certified by the mutual insurance holding company's secretary, of such bylaws and of every modification thereof or addition thereto, which shall be subject to the approval of the commissioner. The insurer shall not, after receiving written notice of such disapproval and during the existence thereof, effectuate any bylaw provision disapproved by the commissioner.

HISTORY: Laws, 1998, ch. 576, § 31, eff from and after July 1, 1998.

§ 83-31-165. Directors.

(1) The affairs of every mutual insurance holding company shall be managed by not less than five (5) directors.

(2) Directors shall be elected by the members of the mutual insurance holding company at the annual meeting of members. Directors may be elected for terms of not more than three (3) years each and until their successors are elected and have qualified, and, if to be elected for terms of more than one (1) year, the mutual insurance holding company's bylaws may provide for a classified board under which the terms of a proportionate part of the members of the board of directors shall expire on the date of each annual meeting of members.

(3) If so provided in a mutual insurance holding company's bylaws, a director of such mutual insurance holding company must be a policyholder of a subsidiary insurance company of the mutual insurance holding company.

HISTORY: Laws, 1998, ch. 576, § 32, eff from and after July 1, 1998.

§ 83-31-167. Dissolution, liquidation, commissioner jurisdiction and investments.

(1) A mutual insurance holding company and, if applicable, an intermediate holding company shall not be dissolved or liquidated without the approval of the commissioner.

(2) The commissioner shall retain jurisdiction over a mutual insurance holding company incorporated in this state and, if applicable, an intermediate holding company, to assure that policyholder interests are protected, including, but not limited to, regulation of the solvency of such companies.

(3) Subject to the limitations of Section 83-6-2, a mutual insurance holding company formed under Section 83-31-47 or 83-31-101 through 83-31-181 may (a) invest in the stock or debt securities of one or more intermediate holding companies; (b) invest in the stock or debt securities of one or more domestic or foreign insurance companies; (c) exercise any power or engage in any transaction or activity permitted by Section 83-31-157 or other provision applicable to mutual insurance holding companies; and (d) invest in any corporation, partnership, limited liability company, business trust or other entity permitted for a mutual insurance company under the laws of this state.

HISTORY: Laws, 1998, ch. 576, § 33, eff from and after July 1, 1998.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section 83-31-47 or 83-31-101 through 83-31-181" for "Sections 83-31-47 or 83-31-101 through 83-31-181" near the beginning of (3). The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-31-169. Membership requirements.

(1) Membership in a mutual insurance holding company shall be determined in accordance with the mutual insurance holding company's articles of association and bylaws and, subject to such exceptions as are set forth in the articles of association or bylaws, shall be based upon each member's holding a policy of insurance with a subsidiary insurance company.

(2) Any person, public or private corporation, board, association, firm, estate, trustee or fiduciary may be a member of a mutual insurance holding company.

(3) No member of a mutual insurance holding company may transfer membership or any right arising therefrom.

(4) A member of a mutual insurance holding company is not, as such, personally liable for the acts, debts, liabilities or obligations of the company and may not be assessed by the directors of such company.

(5) A membership interest in a mutual insurance holding company shall not constitute a security as defined by Section 75-71-105 and shall not be subject to any requirements of the Mississippi Securities Act, Section 75-71-101 et seq.

HISTORY: Laws, 1998, ch. 576, § 34, eff from and after July 1, 1998.

§ 83-31-171. Voluntary dissolution.

(1) Upon any voluntary dissolution of a domestic mutual insurance holding company, its assets remaining after discharge of its indebtedness, if any, and expenses of administration shall be distributed to existing persons who were its members at any time within the three-year period preceding the date such liquidation was authorized or ordered or date of last termination of the insurer's certificate of authority, whichever date is earlier; except, if the commissioner has reason to believe that those in charge of the management of the mutual insurance holding company have caused or encouraged the reduction of the number of members of the insurer in anticipation of liquidation and for the purpose of reducing thereby the number of persons who may be entitled to share in distribution of the insurer's assets, the commissioner may enlarge the three-year qualification period by such additional time as the commissioner may deem to be reasonable.

(2) The distributive share of each such member shall be determined by a formula based upon such reasonable classifications of members as the commissioner may approve.

HISTORY: Laws, 1998, ch. 576, § 35, eff from and after July 1, 1998.

§ 83-31-173. Provisions applicable to mutual insurance holding companies; exemptions from certain provisions.

Each mutual insurance holding company shall be subject to the applicable laws and rules of this state relating to insurance holding company systems. A mutual insurance holding company shall not be subject to provisions of Title 83 of the Mississippi Code or rules adopted thereunder with respect to the writing of insurance or required capital or surplus. A mutual insurance holding company system shall be considered an insurance holding company system but shall not require separate approval under Section 83-31-1 et seq. for an acquisition of controlling stock, ownership interest, assets or control or for a merger or consolidation, share exchange, organization, or reorganization of insurance companies or other transaction with respect to any action approved under the provisions of Section 83-31-47 or 83-31-101 through 83-31-181.

HISTORY: Laws, 1998, ch. 576, § 36, eff from and after July 1, 1998.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section 83-31-47 or 83-31-101 through 83-31-181" for "Sections 83-31-47 or 83-31-101 through 83-31-181" at the end of the last sentence. The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-31-175. Actions challenging validity.

An action challenging the validity of or arising out of acts taken or proposed to be taken regarding a plan of reorganization under Section 83-31-47 or 83-31-101 through 83-31-181 must begin in the Chancery Court of the First Judicial District of Hinds County, Mississippi, not later than the thirtieth day after the effective date of the plan of reorganization.

HISTORY: Laws, 1998, ch. 576, § 38, eff from and after July 1, 1998.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section 83-31-47 or 83-31-101 through 83-31-181" for "Sections 83-31-47 or 83-31-101 through 83-31-181" in the middle of the section. The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-31-177. Mutual insurance holding company conversion to stock holding company.

A mutual insurance holding company may become a stock holding company under such plan and procedure as may be approved by the commissioner and as provided in Section 83-31-101 et seq.

HISTORY: Laws, 1998, ch. 576, § 37, eff from and after July 1, 1998.

§ 83-31-179. Fees, costs and expenses.

(1) A director, officer, agent or employee of the mutual insurance company may not receive a fee, commission or other consideration other than that person's usual salary or compensation for aiding, promoting or assisting in a plan of reorganization under Sections 83-31-47 or 83-31-101 through 83-31-181, except as provided by the plan of reorganization approved by the commissioner.

(2) All the costs and expenses connected with a plan of reorganization shall be paid for or reimbursed by the mutual insurance company or the mutual insurance holding company.

HISTORY: Laws, 1998, ch. 576, § 39, eff from and after July 1, 1998.

§ 83-31-181. Rules and regulations.

The commissioner may adopt rules and regulations implementing the provisions of Sections 83-31-101 through 83-31-179, including, but not limited to, the regulation of the solvency of mutual insurance holding companies and intermediate holding companies.

HISTORY: Laws, 1998, ch. 576, § 40, eff from and after July 1, 1998.

CHAPTER 33.

RECIPROCAL INSURANCE

Sec.

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§ 83-33-1. Regulation of exchange.

Individuals, partnerships, corporations, limited liability companies, public hospitals, including community hospitals, and all other types of entities authorized to exist under the laws of this state, designated as subscribers, may exchange reciprocal or inter insurance contracts with each other or with individuals and all types of entities authorized to exist under the laws of other states, territories, districts and countries, providing insurance or indemnity among themselves from any loss which may be insured against under other provisions of the law except life insurance.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209t; 1930, § 5291; 1942, § 5805; Laws, 1918, ch. 190; Laws, 1995, ch. 313, § 1; Laws, 2013, ch. 459, § 1, eff from and after July 1, 2013.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 127, 132.

CJS.
46 C.J.S., Insurance § 1946.

§ 83-33-3. Execution of contracts.

Such contracts may be executed by an attorney, agent, or other representative, herein designated attorney, duly authorized and acting for said subscribers, and such attorney may be a corporation or limited liability company. The office or offices of such attorney may be maintained at such place or places as may be designated by the subscribers in the power of attorney.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209u; 1930, § 5292; 1942, § 5806; Laws, 1918, ch. 190; Laws, 2013, ch. 459, § 2, eff from and after July 1, 2013.

Cross References — Exclusion of reciprocal contracts from requirement that insurance policies be written by resident local agents, see § 83-17-21.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 133.	46 C.J.S., Insurance § 1948.

§ 83-33-5. Declaration under oath.

Such subscribers so contracting among themselves shall, through their attorney, file with the Commissioner of Insurance a declaration verified by the oath of such attorney or, where such attorney is a corporation, by the oath of the proper officer thereof, setting forth:

(a) The name of the reciprocal, which name shall not be so similar to any name adopted by any insurance organization authorized to write the same class of insurance in this state as to confuse or deceive.

(b) The address of the reciprocal's principal office.

(c) The name of the attorney and address of its principal office.

(d) The kind or kinds of insurance to be effected or exchanged.

(e) A copy of the form of policy contract or agreement under or by which such insurance is to be effected or exchanged.

(f) A copy of the form of power of attorney or other authority of such attorney under which such insurance is to be effected or exchanged.

(g) The location of office or offices from which such contracts or agreements are to be issued.

(h) That applications have been made for indemnity upon at least ten (10) separate risks aggregating not less than One Million Five Hundred Thousand Dollars ($1,500,000.00), as represented by executed contracts or bona fide applications to become concurrently effective; or in case of employers' liability or similar classes of insurance, covering a total payroll of not less than Two Million Five Hundred Thousand Dollars ($2,500,000.00).

(i) That there is in the possession of such attorney and available for the payment of losses, assets conforming to Section 83-33-11.

(j) A financial statement in form prescribed for the annual statement.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209v; 1930, § 5293; 1942, § 5807; Laws, 1918, ch. 190; Laws, 2013, ch. 459, § 3, eff from and after July 1, 2013.

Cross References — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance §§ 128-141.	46 C.J.S., Insurance §§ 1945 et seq.

§ 83-33-7. Commissioner as agent for service of process; reciprocal may sue or be sued in its own name; prohibition against suing subscribers.

Any reciprocal doing business in this state may sue or be sued in its name as set forth in its certificate of authority or license. Concurrently with the filing of the declaration provided by the terms of Section 83-33-5, the attorney shall file with the Commissioner of Insurance an instrument in writing, executed by him for said subscribers, conditioned that upon the issuance of certificates of authority provided in Section 83-33-17 action may be brought in the county in which the property or person insured thereunder is located, and service of process may be had upon the Commissioner of Insurance in all suits in this state arising out of such policies, contracts, or agreements, which service shall be valid and binding upon the reciprocal. Three (3) copies of each process shall be served, and the Insurance Department shall file one (1) copy, forward one (1) copy to said attorney, and return one (1) copy with his admission of service. All suits of every kind and description brought against such reciprocal must be brought against the reciprocal as such, and shall not and may not be brought against any of the subscribers thereto individually on account of their connection with or membership in such reciprocal, and must be brought in the manner and method above provided. A judgment rendered in any such case where service of process has been so had upon the Commissioner of Insurance shall be valid and binding against the reciprocal, and such judgment may only be satisfied solely out of the funds of the reciprocal.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209w; 1930, § 5294; 1942, § 5808; Laws, 1918, ch. 190; Laws, 2013, ch. 459, § 4, eff from and after July 1, 2013.

Cross References — Notification of attorney following service of process upon commissioner, see § 83-5-11.

For the rule controlling service of process on reciprocal insurance companies, see Miss. Rule of Civil Proc. 4.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 139.	46 C.J.S., Insurance § 1962.

§ 83-33-9. Maximum risk.

There shall be filed with the insurance commissioner by such attorney, whenever the insurance commissioner shall so require, a statement under the oath of such attorney showing in the case of fire insurance the maximum amount of indemnity upon a single risk; and no subscriber shall assume on any single fire insurance risk an amount greater than ten percent (10%) of the net worth of such subscriber.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209x; 1930, § 5295; 1942, § 5809; Laws, 1918, ch. 190.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 134-138.

CJS.
46 C.J.S., Insurance § 1951.

§ 83-33-11. Assets maintained.

(1) There shall be maintained at all times assets in cash or securities authorized by the laws of this state for the investment of funds of insurance companies doing the same kind of business, an amount equal to one hundred percent (100%) of the unearned premiums or deposits collected and credited to the accounts of subscribers, or fifty percent (50%) of the advance premiums or deposits collected and credited to the accounts of subscribers on policies having one (1) year or less to run, pro rata on those for longer periods. In addition to the foregoing sum in the case of liability insurance, there shall be maintained as a reserve assets sufficient to discharge all liabilities on all outstanding claims, both reported and incurred but not reported, arising under all policies issued, the same to be calculated on the basis of premiums or deposits as in this section defined and in accordance with the laws of the state relating to similar reserves for companies insuring similar risks. Premiums or deposits as used in this section shall be construed to mean the advance payments made by subscribers. If at any time the assets on hand are less than the foregoing requirements or less than One Hundred Thousand Dollars ($100,000.00), whichever is the greater, where the attorney is exchanging contracts covering employers' liability or similar classes of insurance, the reciprocal shall make up the deficiency. Whenever such assets are less than the amount above required or less than Fifty Thousand Dollars ($50,000.00), whichever is the greater, if the attorney is exchanging contracts other than those covering employers' liability or similar classes of insurance, the reciprocal shall make up the deficiency.

(2) Notwithstanding subsection (1) of this section, a reciprocal authorized to transact business under this chapter shall comply with the minimum capital, surplus and reserve requirements of a stock company writing similar lines of insurance.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209y; 1930, § 5296; 1942, § 5810; Laws, 1918, ch. 190; Laws, 1995, ch. 313, § 2; Laws, 2013, ch. 459, § 5, eff from and after July 1, 2013.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance §§ 71, 72.	44 C.J.S., Insurance §§ 121-123, 132, 133.

§ 83-33-13. Financial reports.

Such reciprocal shall, within the time limited for filing the annual report by insurance companies transacting the same kind of business, make a report to the Commissioner of Insurance for each calendar year showing the financial condition of affairs at the office where such contracts are issued, and shall furnish such additional information and reports as may be required to show the total premiums or deposits collected, the total losses paid, the total amounts returned to subscribers, and the amounts retained for expenses, provided, however, that such reciprocal shall not be required to furnish the names and addresses of any subscribers. The business affairs and assets of such organization shall be subject to examination by the Commissioner of Insurance at the expense of the office examined.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209z; 1930, § 5297; 1942, § 5811; Laws, 1918, ch. 190; Laws, 2013, ch. 459, § 6, eff from and after July 1, 2013.

Cross References — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 70.	44 C.J.S., Insurance §§ 96, 128.

§ 83-33-15. Penalty.

Any attorney who shall exchange any contracts of insurance of the kind and character specified in this chapter or any attorney or representative of such attorney who shall solicit or negotiate any application for same without the attorney first complying with the foregoing provisions shall be deemed guilty of a misdemeanor and, on conviction thereof, shall be subjected to a fine of not less than One Hundred Dollars ($100.00) nor more than One Thousand Dollars ($1,000.00). For the purpose of organization and upon issuance of permit by the Commissioner of Insurance, powers of attorney may be solicited without license; but no attorney, agent, or other persons shall effect any such contracts of insurance until all the provisions of this chapter shall have been complied with.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209a1; 1930, § 5298; 1942, § 5812; Laws, 1918, ch. 190; Laws, 2013, ch. 459, § 7, eff from and after July 1, 2013.

Cross References — Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance §§ 127, 132.	46 C.J.S., Insurance § 1946.

§ 83-33-17. Certificate of authority.

Upon compliance with the foregoing requirements and the payment of the fees and taxes provided in this chapter, the Commissioner of Insurance shall issue a certificate of authority to the reciprocal. The Commissioner of Insurance may revoke or suspend any certificate of authority issued hereunder in case of breach of any of the conditions imposed by this chapter after reasonable notice has been given to the reciprocal in writing, so that the reciprocal may appear and show cause why such action should not be taken. Any reciprocal who may have procured a certificate of authority hereunder may have the same renewed annually thereafter, provided that any certificate of authority issued shall continue in force and effect until a new certificate of authority is issued or specifically refused.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209b1; 1930, § 5299; 1942, § 5813; Laws, 1918, ch. 190; Laws, 2013, ch. 459, § 8, eff from and after July 1, 2013.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance §§ 127, 132.	46 C.J.S., Insurance § 1946.

§ 83-33-19. Taxation of premium receipts.

Such reciprocal shall upon the issuance of the certificate of authority herein provided pay to the state the sum of Two Hundred Dollars ($200.00), as provided in Section 27-15-83, and with the filing of the annual report herein provided shall pay an annual tax upon the gross premiums or deposits collected from subscribers in this state during the preceding calendar year, after deducting therefrom returns for cancellations, considerations for reinsurance, and all amounts returned to subscribers or credited to their account as savings, as provided in Section 27-15-103 et seq.

HISTORY: Codes, Hemingway's 1921 Supp. § 5209c1; 1930, § 5300; 1942, § 5814; Laws, 1918, ch. 190; Laws, 1978, ch. 441, § 6; Laws, 2013, ch. 459, § 9, eff from and after July 1, 2013.

Cross References — Premium taxes imposed by privilege tax code, see §§ 27-15-103 et seq.

RESEARCH REFERENCES

ALR.
Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

Am. Jur.
43 Am. Jur. 2d, Insurance § 133.

CJS.
46 C.J.S., Insurance § 1948.

§ 83-33-21. Subscriber's agreement and power of attorney.

(1) Every subscriber of a domestic reciprocal may execute a subscriber's agreement and power of attorney setting forth the rights, privileges and obligations of the subscriber as an underwriter and as a policyholder, and the powers and duties of the attorney and reciprocal.

(2) If a domestic reciprocal requires execution of a subscriber's agreement and power of attorney by a subscriber, then the subscriber, by its execution, shall be bound by the terms and conditions of the subscriber's agreement and power of attorney.

(3) If a domestic reciprocal does not require execution of a subscriber's agreement and power of attorney, the reciprocal shall include on its policies a statement that the subscriber shall be bound by the terms and conditions of the then current subscriber's agreement and power of attorney on file with and as approved by the Commissioner of Insurance, and each subscriber shall by operation of law be bound by such subscriber's agreement and power of attorney as if individually executed by such subscriber. Without additional execution, notice or acceptance, every subscriber of a reciprocal agrees to be bound by any modification of the terms of the subscriber's agreement and power of attorney which is jointly made by the attorney and the board of directors and amendments thereto, which shall be on file with the attorney and Commissioner of Insurance, which shall become effective upon its approval by the Commissioner of Insurance, and which shall by operation of law bind all subscribers the same as if each subscriber adopted and executed the modified subscriber's agreement and power of attorney. No such modification shall be effective retroactively, nor shall it affect any insurance contract issued prior to the modification. The Commissioner of Insurance's approval shall be deemed given if the subscriber's agreement and power of attorney or any amendment is not disapproved within thirty (30) days of its filing.

HISTORY: Laws, 2013, ch. 459, § 10, eff from and after July 1, 2013.

§ 83-33-23. Board of directors to control and manage reciprocal.

The board of directors for the reciprocal shall have and exercise the ultimate power over the control and management of the affairs of the reciprocal, subject to the subscriber's agreement. The board of directors shall be selected under rules adopted by the subscribers. At least two-thirds (⅔) of the board of directors of a domestic reciprocal shall be composed of subscribers or representatives of subscribers, other than the attorney or any person employed by or having a financial interest in the attorney. An individual shall not be considered to be employed by or having a financial interest in the attorney if such individual is a subscriber or a representative of a subscriber of the reciprocal. The board of directors may also be referred to as a subscribers advisory committee, board of trustees or by such other name as the board chooses.

HISTORY: Laws, 2013, ch. 459, § 11, eff from and after July 1, 2013.

§ 83-33-25. Return of savings or credits accruing to subscribers.

A reciprocal may return to its subscribers any savings or credits accruing to their accounts.

HISTORY: Laws, 2013, ch. 459, § 12, eff from and after July 1, 2013.

§ 83-33-27. Certificate to issue nonassessable policies of insurance.

(1) A domestic reciprocal insurer may apply for a certificate to issue nonassessable policies of insurance. A nonassessable policy is a policy in which a subscriber may not be assessed pursuant to Sections 83-33-29 and 83-33-31. If a domestic reciprocal insurer has a surplus of assets over all liabilities at least equal to the minimum capital and surplus required to be maintained by a domestic stock insurer authorized to transact like kinds of insurance, upon application by the domestic reciprocal insurer the Commissioner of Insurance shall issue a certificate of nonassessability authorizing the insurer to omit provisions imposing contingent assessment liability in all policies delivered or issued or renewed.

(2) If a domestic reciprocal insurer's surplus of assets over all liabilities falls below the minimum capital and surplus required to be maintained by a domestic stock insurer authorized to transact like kinds of insurance, the Commissioner of Insurance may forthwith revoke the certificate of nonassessability. The revocation shall not render subject to contingent assessment liability any policy then in force.

HISTORY: Laws, 2013, ch. 459, § 13, eff from and after July 1, 2013.

Cross References — Reciprocals prohibited from issuing nonassessable policies unless issued a certificate of nonassessability pursuant to this section, see § 83-33-29.

§ 83-33-29. Issuing nonassessable policies without obtaining certificate of nonassessability prohibited; contingent assessment liability.

(1) Any domestic reciprocal insurer that has not been issued a certificate allowing it to issue nonassessable policies as provided in Section 83-33-27 shall

issue assessable policies. An assessable policy is a policy in which the insurer charges an initial premium but may later charge an additional premium in accordance with the provisions of this section and Section 83-33-31.

(2) The contingent assessment liability on any one (1) policy in any one (1) calendar year shall equal the premiums earned on the policy for that year multiplied by not less than one (1) nor more than ten (10) as set forth in the policy.

(3) The contingent assessment liability shall not be joint, but shall be individual and several.

(4) Each assessable policy issued by the insurer shall plainly set forth a statement of the contingent assessment liability on the front of the policy in capital letters in not less than ten point type.

HISTORY: Laws, 2013, ch. 459, § 14, eff from and after July 1, 2013.

§ 83-33-31. Computation and timing of assessments levied against subscribers.

(1) Assessments may be levied against the subscribers of a domestic assessable reciprocal in accordance with Section 83-33-29.

(2) Any assessment levied against the subscribers of a domestic assessable reciprocal shall treat all subscribers equally in that each subscriber's assessment shall be at the same multiple of the subscriber's policies' individual earned premium for the period covered by the assessment. However, no assessment shall exceed the aggregate contingent assessment liability computed in accordance with Section 83-33-29. For the purposes of this section, the premiums earned on the subscriber's policies are the gross premiums charged by the reciprocal for the policies, minus any charges not recurring upon the renewal or extension of the policies. No subscriber shall have an offset against any assessment for which the subscriber is liable on account of any claim for unearned premium or losses payable.

(3) Every subscriber of a domestic reciprocal having contingent assessment liability shall be liable for and shall pay the subscriber's share of any assessment computed in accordance with this section if, while such policy is in force, or within three (3) years after its termination, the subscriber is notified:

(a) By the reciprocal or the attorney of the reciprocal's intention to levy an assessment; or

(b) That delinquency proceedings have been instituted against the reciprocal under this title and the department or receiver intends to levy an assessment.

HISTORY: Laws, 2013, ch. 459, § 15, eff from and after July 1, 2013.

§ 83-33-33. Liability of subscribers for reciprocal's debts or obligations.

No subscriber of a reciprocal shall be personally liable for the payment of the reciprocal's debts or obligations. Any judgment obtained against a reciprocal shall be binding and enforceable only upon and against the reciprocal and shall not be binding or enforceable upon or against any of the reciprocal's subscribers. No legal action shall be allowed to be brought or maintained against the subscribers or insureds of a reciprocal for the payment of the reciprocal's debts or obligations; provided, however, nothing in this section shall diminish or eliminate a subscriber's contingent assessment liability under an assessable policy as provided in Sections 83-33-29 and 83-33-31.

HISTORY: Laws, 2013, ch. 459, § 16, eff from and after July 1, 2013.

§ 83-33-35. Applicability of licensing requirements and regulations to employees and agents of reciprocal and its attorney.

The provisions of this code regarding the appointment, licensing, qualification and regulation of insurance agents, brokers and solicitors, do not apply to the reciprocal or its attorney, nor to the salaried representatives of such reciprocal or attorney who receive no commissions, but do apply in the case of any agent, broker or solicitor of any reciprocal who receives any commission.

HISTORY: Laws, 2013, ch. 459, § 17, eff from and after July 1, 2013.

§ 83-33-37. Two or more reciprocals authorized to combine assets and liabilities into one reciprocal.

Two (2) or more reciprocals may combine their assets and liabilities into one (1) reciprocal, subject to the approval of the Commissioner of Insurance.

HISTORY: Laws, 2013, ch. 459, § 18, eff from and after July 1, 2013.

CHAPTER 34.

WINDSTORM UNDERWRITING ASSOCIATION

Sec.
83-34-1. Definitions.
83-34-3. Creation of Mississippi Windstorm Underwriting Association; organizational structure; certain licensed insurers to become assessable insurers; association revenues; association not subject to state bid requirements.
83-34-4. Nonadmitted policy fee; responsibility of surplus lines insurance producer placing insurance through nonadmitted insurer to collect and remit fees; calculation of fee; penalty for nonpayment.
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83-34-35. Commissioner to approve association rates at least adequate to fund annual reinsurance above a certain reserve.
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83-34-39. Repealed.

§ 83-34-1. Definitions.

In this chapter, unless the context otherwise requires:

(a) "Essential property insurance" means insurance against direct loss to property from the risk of windstorm and hail in the manner as defined and limited in the standard real property and contents insurance forms approved by the commissioner. Essential property insurance may include coverage for either the actual cash value or replacement cost value of the structure and contents. Essential property insurance includes builders risks coverage. The extent of risk covered, the insuring language and the exclusions are all subject to approval by the commissioner. Policies, rules and rates shall be filed with the commissioner in the manner provided for insurance companies.

(b) "Association" means the Mississippi Windstorm Underwriting Association established pursuant to the provisions of this chapter.

(c) "Plan of operation" means the plan of operation of the association approved or promulgated by the commissioner pursuant to the provisions of this chapter.

(d) "Insurable property" means real property, and contents therein when requested, at fixed locations in the coast area, which property is determined by the association to be in an insurable condition and otherwise meets the underwriting requirements of the association. Any one- or two-family dwelling built, rebuilt, altered or remodeled in compliance with the applicable building codes, including design-wind requirements, that is not otherwise rendered uninsurable by reason of use, occupancy or state of repair, shall be an insurable risk. Neighborhood area, location and environmental hazards beyond the control of the applicant or owner of the property shall not be considered in determining insurable condition. "Insurable property" shall not include insurance on motor vehicles or creditor placed insurance on mobile homes. "Insurable property" includes mobile homes, modular homes or manufactured housing that are installed in compliance with applicable codes.

(e) "Commissioner" means the Insurance Commissioner of the State of Mississippi.

(f) "Coast area" means Hancock, Harrison, Jackson, Pearl River, Stone and George Counties.

(g)(i) "Net direct premiums," for purposes of calculating percentages of participation for assessable insurers for the year 2007, means gross direct premiums, excluding reinsurance assumed and ceded, written on property in this state for the risk of windstorm and hail less return premiums upon cancelled contracts, dividends paid or credited to policyholders, or the unused or unabsorbed portion of premium deposits. "Net direct premiums" includes the premium charge component for the risk of windstorm and hail to property in all policies, including multiperil and other policies that package or combine coverage for other risks. The plan of operation shall prescribe the portion of premium allocated for the risk of windstorm and hail in multiperil and other policies that package or combine coverage for other risks. "Net direct premiums" shall not include farm property. "Net direct premiums" shall not include the property components of motor vehicles and other mobile property, but includes premiums for the risks of windstorm and hail for mobile homes, modular homes or manufactured housing.

(ii) "Net direct premiums," for purposes of calculating percentages of participation for assessable insurers after the year 2007, means those premiums reported by the assessable insurers in their annual statements to the Department of Insurance that were charged for insurance for any and all risks on real property and contents in the state. The department shall determine which lines of real property and contents insurance shall be included in the calculation of net direct premiums. The included real property and contents insurance lines may be changed from time to time in the discretion of the commissioner. "Net direct premiums" shall not include premiums for insuring farm property that are reported timely to the association as provided in the plan of operation.

(iii) The commissioner is authorized and directed to provide to the association annual statements, other reports and any statistics necessary to provide the information herein required and which the commissioner is hereby authorized and empowered to obtain from any assessable insurer.

(h) "Farm property" means property used for farming purposes; however, it shall not include any property used for dwelling purposes or any outbuildings used in connection therewith.

(i) "Losses" includes expenses for the adjustment and resolution of claims and operational and other general expenses.

(j) "Bonds, loans, lines of credit and indebtedness" include interest, finance charges, and any and all other costs associated with the financing.

(k) "Percentage of participation" for an assessable insurer means the percentage determined by dividing the assessable insurers net direct premiums written in this state in the previous year by the aggregate net direct premiums written in this state by all assessable insurers of the association in the previous year. The percentage of participation may be modified as provided in Sections 83-34-9(3) and 83-34-13(2).

(*l*) "Nonadmitted insurers" means those insurance companies defined in Section 83-21-17, and any other companies and persons selling insurance on risks in Mississippi that are not licensed to do business in the State of Mississippi.

(m) "Agents placing insurance through nonadmitted insurers" means those agents defined in Section 83-21-19 and any other agents placing insurance through a nonadmitted insurer.

(n) "Assessable insurer" means each and every insurer authorized to write, and engaged in writing, property insurance within this state on a direct basis.

(o) "Minimum reserve" means an amount set forth in the plan of operation which is maintained by the association for the payment of salaries and other expenses necessary for the continuous and ongoing operation of the association.

(p) "Recoupable assessment" means any assessment, in whole or in part, that is levied on and payable by assessable insurers to the association which is directly recoverable from policyholders for any covered event. Any assessment levied due to a covered event occurring during the calendar year 2019 shall be a recoupable assessment.

(q) "Nonrecoupable assessment" means any assessment levied on and payable by assessable insurers to the association which is not directly recoverable from policyholders.

(r) "Excess deficit" means a deficit that exceeds available surplus, reinsurance, recoupable and nonrecoupable assessments and other reasonably available assets of the association. The minimum reserve, as set forth in the plan of operation, shall not be considered reasonably available assets of the association when determining whether an excess deficit has occurred.

(s) "Covered event" means an event, such as a hurricane, other windstorm or hailstorm, which causes losses covered by the policies issued by the association to its policyholders.

HISTORY: Laws, 1987, ch. 459, § 2; Laws, 2007, ch. 425, § 5, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 1, eff from and after July 1, 2019.

Editor's Notes — Section 1, Chapter 459, Laws of 1987, provides as follows:

"SECTION 1. The Legislature of the State of Mississippi hereby declares that an adequate market for windstorm and hail insurance is necessary to the economic welfare of the State of Mississippi and that without such insurance the orderly growth and development of the State of Mississippi will be severely impeded; that furthermore, adequate insurance upon property in the coast area is necessary; and that while the need for such insurance is increasing, the market for such insurance is not adequate and is likely to become less adequate in the future. It is the purpose of this act [§§ 83-34-1 et seq.] to provide a mandatory program to assure an adequate market for windstorm and hail insurance in the coast area of Mississippi."

Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

Cross References — Renewal of policies with respect to property meeting definition of "insurable property" under this section, see § 83-34-15.

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ALR.

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What constitutes "direct loss" under windstorm insurance coverage. 65 A.L.R.3d 1128.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 482-484.

44A Am. Jur. 2d, Insurance §§ 1965, 1966, 2049.

CJS.

45 C.J.S., Insurance §§ 996, 998, 1285-1287, 1258, 1843, 1922.

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New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-34-3. Creation of Mississippi Windstorm Underwriting Association; organizational structure; certain licensed insurers to become assessable insurers; association revenues; association not subject to state bid requirements.

(1) From and after March 22, 2007, the Mississippi Windstorm Underwriting Association, as created by Chapter 459, Laws of 1987, shall be a separate and independent entity as provided for herein. At its option, the association may incorporate. All assets belonging to the association on or before March 22, 2007, shall hereinafter belong to and remain with the association. There shall be no distribution of income or assets other than for the benefit of the association, which shall have the right to invest and reinvest assets.

(2) From and after March 22, 2007, the association shall no longer have members. Former "members" of the association shall be "assessable insurers" and shall have no rights to the assets and profits of the association, but shall have the obligation for regular assessments as provided herein. Former members shall continue to have the obligations provided in this chapter before March 22, 2007, for all policyholder claims, costs, damages of any kind and expenses in any manner resulting from losses that occurred before March 22, 2007, for which the association may assess as needed the former members in the manner provided in this chapter before March 22, 2007. As a condition of its authority to continue to transact the business of insurance in this state and by transacting business in this state, each licensed insurer agrees to be bound by the provisions of this statute and the plan of operation as approved by the commissioner, and all amendments and revisions thereto.

(3) Any licensed insurer first authorized to write insurance after March 22, 2007, shall become an assessable insurer on the first day of January immediately following such authorization. The determination of such insurer's participation in the association shall be made based upon writings in the prior year in the same manner as for all other assessable insurers of the association.

(4) Except as provided for in Section 83-34-4(6), the premiums, recoupable and nonrecoupable assessments, fees, investment income and other revenue of the association are funds received for the sole purpose of providing insurance coverage, paying claims for Mississippi citizens insured by the association, securing and repaying debt obligations issued by the association, and conducting all other activities of the association, all as required or permitted by this chapter. Such revenue shall not be considered taxes, fees, licenses or charges for services imposed by the State of Mississippi on individuals, businesses, or agencies, and shall not be used for other purposes.

(5) It is the intent of the Legislature that the association be and act as a nonprofit entity. The association shall be free from taxation of every kind by

the state and any political subdivision or other instrumentality thereof. It is the intent of the Legislature that the association be tax exempt from all taxes, including federal taxes, and the association is granted the authority to take those steps necessary to obtain federal tax exempt status.

(6) Any debt obligations issued by the association, their transfer, and the income therefrom, including any profit made on the sale thereof, shall at all times be free from taxation of every kind by the state and any political subdivision or other instrumentality thereof.

(7) In the event of the termination of the association by act of the Legislature, or other means, the assets of the association shall be applied first to pay all debts, liabilities and obligations of the association, including the establishment of reasonable reserves for any contingent liabilities or obligations, and all remaining assets of the association shall become property of the state.

(8) The association shall operate as a private enterprise and shall not be subject to the procurement provisions of Section 31-7-13, and policies and decisions of the association, including, but not limited to, decisions relating to incurring debt, levying of recoupable and nonrecoupable assessments, the issuance and sale of bonds, claims decisions under association policies, hiring and firing of employees, and all services relating to the operation of the association shall not be subject to the provisions of Section 25-9-101 et seq. The association shall not be required to obtain or to hold a license or certificate of authority issued by the commissioner or any other office. The association shall not be required to participate as a member insurer of the Mississippi Insurance Guaranty Association.

HISTORY: Laws, 1987, ch. 459, § 3; Laws, 2007, ch. 425, § 6; Laws, 2014, ch. 426, § 2, eff from and after July 1, 2014; Laws, 2019, ch. 450, § 2, eff from and after July 1, 2019.

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

Cross References — Effect of insurer's writing any policies that require membership in association pursuant to this section, see § 83-34-9.

Powers and duties of association generally, see § 83-34-5.

Nonadmitted insurers are not assessable insurers of the association, see § 83-34-4.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 69, 482-484.

44A Am. Jur. 2d, Insurance §§ 1965, 1966, 2049.

CJS.

45 C.J.S., Insurance §§ 996, 998, 1255, 1256, 1258, 1285-1287.

46 C.J.S., Insurance §§ 1843, 1922.

§ 83-34-4. Nonadmitted policy fee; responsibility of surplus lines insurance producer placing insurance through nonadmitted insurer to collect and remit fees; calculation of fee; penalty for nonpayment.

(1) Nonadmitted insurers shall not be assessable insurers of the association. All surplus lines insurance producers placing insurance through nonadmitted insurers shall collect from the insured and remit to the association a nonadmitted policy fee on all premiums for all insurance written by such surplus lines insurance producer for a policy from a nonadmitted insurer for any and all risks in this state, except that policies or portions thereof that cover residential earthquake risks or residential flood risks that are not written through the National Flood Insurance Program shall be exempt from the nonadmitted policy fee. By procuring or selling insurance on property in this state from a nonadmitted insurer, each surplus lines insurance producer placing insurance through a nonadmitted insurer agrees to be bound by the provisions of this chapter and to collect and remit the nonadmitted policy fee provided for herein.

(2) The nonadmitted policy fee shall be a percentage of the total policy premium but the nonadmitted policy fee shall not be considered premium and is not subject to premium taxes or commissions. However, failure to pay the nonadmitted policy fee shall be treated the same as failure to pay premium. "Total policy premium" includes taxes and commissions.

(3) The nonadmitted policy fee percentage shall be three percent (3%).

(4) Within twenty (20) days of the end of the quarter, surplus lines insurance producers placing insurance through nonadmitted insurers shall remit directly to the association all nonadmitted policy fees collected in the preceding quarter. In addition to the nonadmitted policy fee provided for herein, surplus lines insurance producers placing insurance through nonadmitted insurers shall collect and remit excess deficit surcharges as provided by this chapter. Surplus lines insurance producers placing insurance through nonadmitted insurers may designate another surplus lines insurance producer that actually procured the insurance from the nonadmitted carrier to collect and remit the nonadmitted policy fees.

(5) Each insured in this state who directly procures or renews insurance with a nonadmitted insurer on properties, risks or exposures located or to be performed, in whole or in part, in this state, other than insurance procured through a surplus lines licensee, shall be subject to the nonadmitted policy fee which shall be paid by the insured according to the procedures provided for premium taxes in Section 83-21-17(5).

(6) Monies derived from the nonadmitted policy fee collected under this section shall not be considered public funds and may be used by the association, in addition to any uses provided for in Section 83-34-3(4), for education, public outreach, training of building officials and other programs targeted to reduce the number of policies within the association; however, beginning on July 1, 2018, and ending on June 30, 2019, before any fees are remitted to the

association, One Million Five Hundred Thousand Dollars ($1,500,000.00) shall be diverted and deposited into the Capital Expense Fund, and Four Million Five Hundred Thousand Dollars ($4,500,000.00) shall be diverted and deposited into the Rural Fire Truck Fund or Supplementary Rural Fire Truck Fund. Further, beginning July 1, 2019, and ending on June 30, 2020, before any fees are remitted to the association, Three Million Five Hundred Thousand Dollars ($3,500,000.00) shall be diverted and deposited into the Rural Fire Truck Fund or Supplementary Rural Fire Truck Fund. Further, beginning July 1, 2022, before any fees are remitted to the association but only if the association will receive at least sixty percent (60%) of the fees, Five Hundred Thousand Dollars ($500,000.00) shall be diverted and deposited annually into the Mississippi First Responders Health and Safety Trust Fund created in Section 25-15-411. Further, beginning July 1, 2022, but only if the association will receive at least sixty percent (60%) of the fees and the Mississippi First Responders Health and Safety Trust Fund has received the diversion of Five Hundred Thousand Dollars ($500,000.00), Three Million Five Hundred Thousand Dollars ($3,500,000.00) shall be diverted and deposited annually into the Annual Fire Fund created in Section 17-23-21. Further, beginning July 1, 2022, after the association has received sixty percent (60%) of the fees and after all other diversions are made, fifty percent (50%) of any excess amount shall be remitted to the association and fifty percent (50%) of any excess amount shall be diverted and deposited annually into the Annual Fire Fund.

In the event the value of the association's Total Admitted Assets, as defined by the audited financial statement, is less than Two Hundred Fifty Million Dollars ($250,000,000.00), the monies diverted and not remitted to the association under this subsection (6) during that fiscal year and subsequent fiscal years shall immediately be diverted to the association and shall not be considered public funds.

(7) The association may use excess funds to purchase reinsurance in an amount that may exceed the total premiums collected from policyholders.

HISTORY: Laws, 2007, ch. 425, § 7; Laws, 2011, ch. 380, § 9; Laws, 2012, ch. 375, § 1; Laws, 2014, ch. 426, § 1 eff from and after July 1, 2014; Laws, 2018, ch. 459, eff from and after July 1, 2018; Laws, 2019, ch. 450, § 3, eff from and after July 1, 2019; Laws, 2022, ch. 476, § 1, eff from and after July 1, 2022.

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

Amendment Notes — The 2022 amendment, in (6), inserted "shall not be considered public funds and," added the last three sentences, and added the last paragraph; and in (7), deleted the repealer for the section, and added "The association may…collected from policyholders."

Cross References — Rural Fire Truck Fund, see § 17-23-1.

§ 83-34-5. Powers and duties.

The association shall, pursuant to the provisions of this chapter and the plan of operation, and with respect to essential property insurance on insurable property, have the power:

(a) To issue policies of essential property insurance on insurable property to applicants;

(b) At its option, and with consent of the commissioner, to issue policies of related essential property insurance on insurable property to applicants;

(c) To purchase reinsurance for all or part of the risks of the association;

(d) To levy and collect recoupable and nonrecoupable assessments from assessable insurers;

(e) To issue bonds or incur other forms of indebtedness, including, but not limited to, loans, lines of credit or letters of credit;

(f) To establish underwriting criteria consistent with the provisions of this chapter and as approved by the commissioner;

(g) To invest and reinvest income and assets subject to the oversight of the commissioner;

(h) To enter into contractual agreements with third parties, including the Mississippi Windstorm Mitigation Coordinating Council, for the purposes of developing and implementing windstorm mitigation programs; and

(i) All other powers necessary to carry out the provisions and intent of this chapter.

HISTORY: Laws, 1987, ch. 459, § 4; Laws, 2007, ch. 425, § 8; Laws, 2011, ch. 460, § 2, eff from and after July 1, 2011; Laws, 2019, ch. 450, § 4, eff from and after July 1, 2019.

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

Cross References — Plan of operation, see § 83-34-13.

Mississippi Winstorm Mitigation Coordinating Council, see § 83-1-201.

§ 83-34-7. Designation of temporary board of directors; expiration of terms of office; permanent board of directors; composition of board; selection and qualifications of board members; terms of office; powers.

(1) The Board of Directors of the Mississippi Insurance Underwriting Association as presently constituted shall serve as the temporary board of directors of the association. Such temporary board of directors shall prepare and submit a plan of operation in accordance with Section 83-34-13 and shall serve until the permanent board of directors shall take office in accordance with the plan of operation. The permanent board shall consist of five (5) representatives of the members to be appointed by the temporary board of directors subject to the approval of the commissioner and three (3) agents from the coast area to be appointed by the commissioner. The terms of the members of the board of directors in place before March 22, 2007, shall expire on March 22, 2007, and such persons shall cease to serve on the board and shall relinquish all power and control of the association.

(2)(a) From and after March 22, 2007, the board of directors of the association shall consist of the following:

(i) The State Treasurer;

(ii) Five (5) of the assessable insurer companies, three (3) to be appointed by the commissioner, one (1) to be appointed by the Governor, and one (1) to be appointed by the Lieutenant Governor; each such assessable insurer appointed shall designate a representative knowledgeable in the matters of the association and authorize such representative to act and vote on its behalf;

(iii) Three (3) agents with no less than ten (10) years' experience in the property and casualty industry, two (2) of whom are residents in the coast area, and one (1) of whom is not a resident of the coast area; one (1) such coast area agent to be appointed by the Governor, one (1) such coast area agent to be appointed by the Lieutenant Governor, and the noncoast area agent to be appointed by the commissioner; and

(iv) Two (2) business leaders who have been residents of the coast area for no less than ten (10) years and who have no less than ten (10) years' experience in management of a business, one (1) to be appointed by the Governor, and one (1) to be appointed by the Lieutenant Governor.

(b) Except for the State Treasurer, the board members shall serve three-year terms with each term beginning on January 1, and the initial terms shall be staggered in the following manner:

(i) The initial term for three (3) of the assessable insurers shall begin on March 22, 2007, and expire on December 31, 2010, thereafter to be appointed for three-year terms;

(ii) The initial term for one (1) of the assessable insurers shall begin on March 22, 2007, and expire on December 31, 2009, thereafter to be appointed for three-year terms;

(iii) The initial term for one (1) of the assessable insurers shall begin on March 22, 2007, and expire on December 31, 2008, thereafter to be appointed for three-year terms;

(iv) The initial term for one (1) of the agents shall begin on March 22, 2007, and expire on December 31, 2010, thereafter to be appointed for three-year terms;

(v) The initial term for one (1) of the agents shall begin on March 22, 2007, and expire on December 31, 2009, thereafter to be appointed for three-year terms;

(vi) The initial term for one (1) of the agents shall begin on March 22, 2007, and expire on December 31, 2008, thereafter to be appointed for three-year terms;

(vii) The initial term for one (1) of the business leaders shall begin on March 22, 2007, and expire on December 31, 2010, thereafter to be appointed for three-year terms;

(viii) The initial term for one (1) of the business leaders shall begin on March 22, 2007, and expire on December 31, 2008, thereafter to be appointed for three-year terms.

(3) On or before March 22, 2007, the appropriate public official shall make such appointments and request such resignations from the existing board as are appropriate to comply with this section.

(4) The board shall be staffed by as many employees as it deems necessary.

(5) The board of directors has the power to act and make binding decisions on behalf of the association on all issues.

HISTORY: Laws, 1987, ch. 459, § 5; Laws, 2007, ch. 425, § 9, eff from and after passage (approved Mar. 22, 2007).

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

JUDICIAL DECISIONS

1. Liability.

Representatives of insurer directors of Mississippi Windstorm Underwriting Association were not entitled to summary judgment under Fed. R. Civ. P. 56 because disputed issues existed as to whether the representatives were in fact members of the board of directors under Miss. Code Ann. § 83-34-7 or whether their assumed duties made them liable to members of the association based on breach of fiduciary duty or negligence. Ass'n Cas. Ins. Co. v. Allstate Ins. Co., 245 F.R.D. 245, 2007 U.S. Dist. LEXIS 61081 (S.D. Miss. 2007).

§ 83-34-9. Participation by assessable insurers in recoupable and nonrecoupable assessments levied by association; financial incentives and/or penalties to ensure assessable insurers write insurance in the coast area.

(1) All assessable insurers of the association shall participate in recoupable and nonrecoupable assessments levied by the association based upon their percentage of participation. The association may allow affiliated insurers to combine their annual net direct premiums and other data, including data that supports any incentives that may be allowed by the association, to the extent that such grouping promotes the voluntary writing of essential property insurance in the coast area. Any provisions for credits and grouping of data shall be prescribed in the plan of operation.

(2) All profits of the association shall remain as assets of the association.

(3) The plan of operation shall provide financial incentives or financial penalties, or both, to ensure that assessable insurers write essential property insurance in the coast area. The incentives and penalties may include, but are not limited to, a reduction in recoupable and nonrecoupable assessments, adjustments in the percentage of participation, and other incentives and penalties as provided in the plan of operation. The commissioner shall approve the plan of operation as provided in Section 83-34-13.

HISTORY: Laws, 1987, ch. 459, § 6; Laws, 2007, ch. 425, § 10, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 5, eff from and after July 1, 2019.

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

Cross References — Power to levy regular assessments upon occurrence of certain events, see § 83-34-10.

Deferment of assessable insurer's regular assessment, see § 83-34-12.

Plan of operation generally, see § 83-34-13.

Applicability of this section to assessment amounts ordered deferred with respect to one member insurer and assessed against other member insurers, see § 83-34-15.

JUDICIAL DECISIONS

1. Association's negligent misrepresentation.

Underwriting association erred in denying an insurer's request to submit corrected data from which the insurer's participation in the association's insurance pool was calculated, after a deadline, because the association's negligent misrepresentation to the insurer caused the untimely submission, tolling the deadline as applied to the insurer, as (1) the association did not correct a mistaken response, (2) the misrepresentation that the insurer could not receive credits for excess policies was material, (3) the association's decision to provide wrong information showed a lack of diligence the public was entitled to expect, (4) the insurer reasonably relied on the representation and was damaged by not receiving credits the insurer was statutorily entitled to, and (5) the deadline was not immutable or not subject to other mitigating principles of law. Arrowood Indem. Co. v. Miss. Windstorm Underwriting Ass'n, 201 So. 3d 453, 2016 Miss. LEXIS 249 (Miss. 2016).

§ 83-34-10. Power to levy recoupable and nonrecoupable assessments upon occurrence of certain events; maximum nonrecoupable assessments.

(1) In the event of a covered event that may produce losses in excess of funds that may be immediately available to the association, or in the event that the association determines that it will otherwise have a claim deficit or any other deficit, then the association, with consent of the commissioner, shall have the power to levy recoupable and nonrecoupable assessments against assessable insurers based upon their percentage of participation.

The minimum reserve, as set forth in the plan of operation, shall not be considered as funds available to the association in determining whether to levy a recoupable or nonrecoupable assessment.

(2) A nonrecoupable assessment levied under this section shall not exceed six percent (6%) of the association's year-end total limits in force for the preceding calendar year, or Two Hundred Fifty Million Dollars ($250,000,000.00), whichever is less. Further, in any calendar year, the annual total of all nonrecoupable assessment funds collected shall not exceed, in the aggregate, Two Hundred Fifty Million Dollars ($250,000,000.00).

HISTORY: Laws, 2007, ch. 425, § 11, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 6, eff from and after July 1, 2019.

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

Cross References — Participation by assessable insurers in regular assessments levied by association, see § 83-34-9.

Deferment of assessable insurer's regular assessment, see § 83-34-12.

§ 83-34-11. Repealed.

Repealed by Laws, 2019, ch. 450, § 13, eff from and after July 1, 2019.

§ 83-34-11. [Laws, 1987, ch. 459, § 7; Laws, 2007, ch. 425, § 12, eff from and after passage (approved Mar. 22, 2007).]

Editor's Notes — Former § 83-34-11 implemented a surcharge on all property and casualty insurance premiums in Mississippi.

§ 83-34-12. Deferment of assessable insurer's recoupable or nonrecoupable assessment; amount deferred to be assessed against other assessable insurers.

The recoupable or nonrecoupable assessment of an assessable insurer may, after hearing, be ordered deferred, in whole or in part, upon application by the insurer if, in the opinion of the commissioner, payment of the recoupable or nonrecoupable assessment would render the insurer insolvent or in danger of insolvency, or would otherwise leave the insurer in such a condition that further transaction of the insurer's business would be hazardous to its policyholders, creditors, assessable insurers, subscribers, stockholders or the public. If that payment of a recoupable or nonrecoupable assessment against an assessable insurer is deferred by order of the commissioner, in whole or in part, the amount by which the recoupable or nonrecoupable assessment is deferred shall be assessed against other assessable insurers in the same manner as provided in Section 83-34-9.

HISTORY: Laws, 2007, ch. 425, § 13, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 7, eff from and after July 1, 2019.

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

Cross References — Power of association to levy regular assessments against assessable insurers, see § 83-34-10.

Participation by assessable insurers in regular assessments levied by association, see § 83-34-9.

§ 83-34-13. Plan of operation; contents; approval by commissioner; certification of approval; effective date of plan.

(1) Within forty-five (45) days after March 22, 2007, the directors of the association shall submit to the commissioner for review and approval a proposed plan of operation revised to be consistent with the provisions of Chapter 425, Laws of 2007. The association shall maintain a plan of operation. The plan shall provide for the efficient, economical, fair and nondiscriminatory administration of the association. The plan may include the establishment of

a minimum reserve, methods for the nonrecoupable assessment of all assessable insurers for deficits and expenses, the establishment of necessary facilities, management of the association, underwriting standards, procedures for determining the amounts of insurance to be provided to specific risks, time limits and procedures for processing applications for insurance, and for such other provisions as may be deemed necessary by the board to carry out the purposes of this chapter. The plan of operation shall include in the plan of operation a mechanism for recoupment of recoupable assessments.

(2) The plan of operation shall provide financial incentives or financial penalties, or both, to ensure that assessable insurers write essential property insurance in the coast area. The incentives and penalties may include, but are not limited to, a reduction in nonrecoupable assessments, adjustments in the percentage of participation, and other incentives and penalties as provided in the plan of operation.

(3) The plan of operation shall provide (a) that the association shall offer a two percent (2%) deductible for loss from named storms; and (b) that the association shall also offer options for other deductibles for loss from named storms with appropriate rate reductions that shall include at least a twenty percent (20%) deductible for loss from named storms.

(4) The plan of operation shall provide that the association use actuarially appropriate geographical zones for rating and for the use of credits and penalties to encourage voluntary writing in the coast area.

(5) The commissioner shall approve the plan of operation and all amendments before they become effective. It is the obligation of the commissioner to confirm that such plan fulfills the purposes of this chapter. If the commissioner approves a proposed plan or amendment, he shall certify the approval to the directors, and the plan, or amendment thereto, shall become effective ten (10) days after such certification. If the commissioner disapproves all or any part of the proposed plan of operation, or amendment thereto, he shall return the same to the directors with a written statement giving the reasons for disapproval and any recommendations the commissioner may wish to make. Within ten (10) days thereafter, the directors may alter the plan or amendment in accordance with the commissioner's recommendation or may return a new plan to the commissioner. The commissioner shall consider the proposals and shall then promulgate and place into effect a plan of operation certifying the same to the directors of the association after approval by the board of directors. Any such plan promulgated by the commissioner shall take effect ten (10) days after certification to the directors.

(6) The commissioner may review the plan of operation at any time he deems expedient or prudent. After review of the plan, the commissioner may amend the plan after consultation with the directors of the association and upon certification to the directors of the amendment.

HISTORY: Laws, 1987, ch. 459, § 8; Laws, 2007, ch. 425, § 14, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 8, eff from and after July 1, 2019.

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

Laws of 2007, ch. 425, added §§ 27-15-133, 83-34-4, 83-34-10, 83-34-12, 83-34-31, 83-34-33, 83-34-35, 83-34-37, and 83-34-39, and amended §§ 83-34-1, 83-34-3, 83-34-5, 83-34-7, 83-34-9, 83-34-11, 83-34-13 through 83-34-23, and 83-34-27.

Cross References — Submission of a plan of operation in accordance with this section by the temporary board of directors of the Windstorm Underwriting Association, see § 83-34-7.

"Coast area" defined, see § 83-34-1.

§ 83-34-15. Application for coverage; inspection of property; issuance of insurance; appeal of denial of application.

(1)(a) Any person having an insurable interest in insurable property is entitled to apply to the association for such coverage. Applications shall be made on behalf of the owner of the insurable interest by a licensed resident broker or agent authorized by him. Applications shall be submitted on forms prescribed by the association.

(b) The association may require an inspection of any properties after application or request for renewal and may charge a fee for such inspection.

(c) The term "insurable interest" as used in this subsection shall be deemed to include any lawful and substantial economic interest in the safety or preservation of property from loss, destruction or pecuniary damage.

(2) If the association determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the association, upon receipt of the premium or such portion thereof as is prescribed in the plan of operation, shall cause to be issued, or issue, a policy of essential property insurance. Such coverage shall be dependent upon the timely payment and actual receipt by the association of premiums or premium installments as provided for at the time of application. Coverage limits shall be determined by the value of the insurable property at the time the policy is issued subject to maximum limits which shall be set forth under the plan of operation.

(3) If the association for any reason denies an application and refuses to issue or cause to be issued an insurance policy to any applicant, or takes no action on an application within the time prescribed in the plan of operation, such applicant may appeal to the commissioner. The commissioner or a designated member of his staff, after reviewing the facts, may direct the association to issue or cause to be issued an insurance policy to the applicant; however, no coverage shall be in effect until such time as the premium is paid and the policy issued. In carrying out his duties pursuant to this section, the commissioner may request, and the association shall provide, any information the commissioner deems necessary to a determination concerning the reasons for the denial or delay of the application.

HISTORY: Laws, 1987, ch. 459, § 9; Laws, 2007, ch. 425, § 15, eff from and after passage (approved Mar. 22, 2007).

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

JUDICIAL DECISIONS

ANALYSIS

1. In general.
2. Under former § 83-35-15.

1. In general.

Servicing insurer was not entitled to a grant of summary judgment because genuine issues of material fact existed as to whether a servicing insurer was an agent for a disclosed principal, the Mississippi Windstorm Underwriting Association, and whether the insurer committed gross negligence regarding the determination of the insureds' losses. Fonte v. Audubon Ins. Co., 8 So. 3d 161, 2009 Miss. LEXIS 86 (Miss. 2009), modified, 2009 Miss. LEXIS 216 (Miss. May 14, 2009).

2. Under former § 83-35-15.

The deposit in the mail of a premium two days prior to the expiration date of the policy was effective to renew the policy even though the premium arrived at the insurance company's office after the expiration date of the policy, since the insurance company had adopted the postal service as its agent and the premium was mailed in apt time to reach the insurance company by the due date. Mississippi Ins. Underwriting Asso. v. Maenza, 413 So. 2d 1384, 1982 Miss. LEXIS 1996 (Miss. 1982).

RESEARCH REFERENCES

ALR.

Causes of loss under windstorm insurance coverage. 93 A.L.R.2d 145.

Temporary fire, wind, or hail insurance pending issuance of policy. 14 A.L.R.3d 568.

What constitutes "direct loss" under windstorm insurance coverage. 65 A.L.R.3d 1128.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 482-484.

44 Am. Jur. 2d, Insurance §§ 1965, 1966.

CJS.

45 C.J.S., Insurance §§ 996, 998, 1255, 1256, 1258, 1285-1287.

46 C.J.S., Insurance §§ 1843, 1922.

§ 83-34-16. Premium discount for building "fortified home."

The Mississippi Windstorm Underwriting Association shall provide a premium discount for any individual who builds a "fortified home" pursuant to the Institute for Business and Home Safety (IBHS). Licensed architects, engineers or inspectors certified by the Department of Insurance shall determine whether a dwelling meets the criteria for a "fortified home" pursuant to the Institute for Business and Home Safety. The Mississippi Windstorm Underwriting Association shall provide a premium discount for any individual who improves his residence with demonstrated mitigation measures that provide protection against damages caused by a windstorm or hurricane.

HISTORY: Laws, 2009, ch. 537, § 2, eff from and after July 1, 2009.

§ 83-34-17. Rates.

The rates, rating plans, rating rules, forms and endorsements applicable to the insurance written by the association shall be those approved for use of the association by the commissioner. Rates shall be nondiscriminatory as to the same class of risk.

HISTORY: Laws, 1987, ch. 459, § 10; Laws, 2007, ch. 425, § 16, eff from and after passage (approved Mar. 22, 2007).

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 40-42.

§ 83-34-19. Appeals.

(1) Any assessable insurer or other licensed insurer, or agent placing insurance through a nonadmitted insurer, who may be aggrieved by an act, order, ruling or decision of the association may, within thirty (30) days after such ruling, appeal to the commissioner. Any hearings held by the commissioner pursuant to such an appeal shall be in accordance with the procedure set forth in the insurance laws of Mississippi. The commissioner is authorized to appoint a member of his staff for the purpose of hearing such appeals, and a ruling based upon such hearing shall have the same effect as if heard by the commissioner. All assessable insurers or other licensed insurers, or agents placing insurance through a nonadmitted insurer, aggrieved by any order or decision of the commissioner may appeal to the Chancery Court of the First Judicial District of Hinds County, Mississippi, consistent with the insurance laws of the State of Mississippi.

(2) The association and any assessable insurer, other licensed insurer or agent placing insurance through a nonadmitted insurer that may be aggrieved by an act, order, ruling or decision of the commissioner may, within thirty (30) days after such act, order, ruling or decision, appeal to the Chancery Court of the First Judicial District of Hinds County, Mississippi, consistent with the insurance laws of the State of Mississippi.

HISTORY: Laws, 1987, ch. 459, § 11; Laws, 2007, ch. 425, § 17, eff from and after passage (approved Mar. 22, 2007).

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

JUDICIAL DECISIONS

1. In general.
Motion to dismiss based on failure to exhaust administrative remedies of Miss. Code Ann. § 83-34-19 was denied because the remedy was inadequate to resolve Mississippi Windstorm Underwriting As-

sociation members' claims regarding the amount of reinsurance, breach of fiduciary duty, and negligence in that the claims did not specifically relate to remedy; there were short, successive deadlines, a lack of objective standards of review under Miss. Code Ann. § 83-34-29, due process concerns, and the members were allegedly unable to discover facts material to exercise the remedy. Ass'n Cas. Ins. Co. v. Allstate Ins. Co., 507 F. Supp. 2d 610, 2007 U.S. Dist. LEXIS 60716 (S.D. Miss. 2007), transferred, 2007 U.S. Dist. LEXIS 106606 (S.D. Miss. Sept. 5, 2007).

Although a litigant was required to exhaust administrative remedies before seeking judicial review, the appellate court declined to decide the appeal on the insureds' failure to exhaust their administrative remedies because the insureds' policy had expired, and they had not submitted an application for renewal. Consequently, the insureds were not an "applicant" or an "insured" within the meaning of the Mississippi Windstorm Underwriting Association's "plan of operation" which provided for appeals by applicants or insureds. Luedke v. Audubon Ins. Co., 874 So. 2d 1029, 2004 Miss. App. LEXIS 540 (Miss. Ct. App. 2004).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 482-484.

44 Am. Jur. 2d, Insurance §§ 1965, 1966.

CJS.

45 C.J.S., Insurance §§ 996, 998, 1255, 1256, 1258, 1285-1287.

46 C.J.S., Insurance §§ 1843, 1922.

§ 83-34-21. Reports of inspection made available.

All reports of inspection performed by or on behalf of the association shall be made available to the assessable insurers of the association, applicants, agents, brokers and the commissioner.

HISTORY: Laws, 1987, ch. 459, § 12; Laws, 2007, ch. 425, § 18, eff from and after passage (approved Mar. 22, 2007).

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

§ 83-34-23. Immunity from liability.

There shall be no liability on the part of the insurance commissioner or any of his staff and representatives for any action taken under and pursuant to the provisions of this chapter. There shall be no liability on the part of the association, its agents, representatives or employees, the members of the board, or any assessable insurer of the association, except for the specific obligations stated in any contract of insurance and the duty to pay assessments as provided in this chapter.

HISTORY: Laws, 1987, ch. 459, § 13; Laws, 2007, ch. 425, § 19, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 9, eff from and after July 1, 2019.

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"

§ 83-34-25. Annual report.

The association shall file in the office of the commissioner on or before March 1 of each year a statement which shall summarize the transactions, conditions, operations and affairs of the association during the preceding fiscal year ending December 31. Such statement shall contain such matters and information as are prescribed by the commissioner and shall be in such form as required by him. The commissioner may at any time require the association to furnish to him any additional information with respect to its transactions or any other matter which the commissioner deems to be material to assist him in evaluating the operation and experience of the association.

HISTORY: Laws, 1987, ch. 459, § 14, eff from and after passage (approved April 14, 1987).

§ 83-34-27. Commissioner may examine affairs of association; commissioner and association may examine data and payments of assessable insurer or insurers placing insurance through nonadmitted insurers.

The commissioner may from time to time make an examination into the affairs of the association when he deems prudent and, in undertaking such examination, may hold a public hearing. The expenses of such examination shall be borne and paid by the association. The association and the commissioner may from time to time make an examination of the data and payments of assessable insurers or other licensed insurers or agents placing insurance through nonadmitted insurers as it deems prudent. The expenses of such examination shall be borne and paid by the examined party or entity. Any person noticed for such examination may appeal the examination or the cost thereof, or both, to the commissioner.

HISTORY: Laws, 1987, ch. 459, § 15; Laws, 2007, ch. 425, § 20, eff from and after passage (approved Mar. 22, 2007).

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.'"
Cross References — "Nonadmitted insurer" defined, see § 83-34-1.

§ 83-34-29. Rules and regulations.

The association is authorized to promulgate rules for the implementation of this chapter, subject to the approval of the commissioner.

HISTORY: Laws, 1987, ch. 459, § 16, eff from and after passage (approved April 14, 1987).

JUDICIAL DECISIONS

1. Relation to exhaustion of remedies.

Motion to dismiss based on failure to exhaust administrative remedies of Miss. Code Ann. § 83-34-19 was denied because the remedy was inadequate to resolve Mississippi Windstorm Underwriting Association members' claims regarding the amount of reinsurance, breach of fiduciary duty, and negligence in that the claims did not specifically relate to remedy; there were short, successive deadlines, a lack of objective standards of review under Miss. Code Ann. § 83-34-29, due process concerns, and the members were allegedly unable to discover facts material to exercise the remedy. Ass'n Cas. Ins. Co. v. Allstate Ins. Co., 507 F. Supp. 2d 610, 2007 U.S. Dist. LEXIS 60716 (S.D. Miss. 2007), transferred, 2007 U.S. Dist. LEXIS 106606 (S.D. Miss. Sept. 5, 2007).

RESEARCH REFERENCES

ALR.

Causes of loss under windstorm insurance coverage. 93 A.L.R.2d 145.

Temporary fire, wind, or hail insurance pending issuance of policy. 14 A.L.R.3d 568.

What constitutes "direct loss" under windstorm insurance coverage. 65 A.L.R.3d 1128.

§ 83-34-31. Powers and authority of board of directors to issue bonds and enter into loans or other forms of indebtedness; rights and remedies of bondholders not to be impaired.

(1) The board of directors, subject to the approval of the commissioner, shall have the power and authority to issue bonds, and the power and authority to enter into loans, letters of credit, lines of credit, and other forms of indebtedness, as needed for operations, the purchase of reinsurance, claim losses, and incurred but not reported claims.

(2) The bonds must be in a form approved by the commissioner. With approval of the commissioner, the association may issue bonds or incur other indebtedness to retire or consolidate bonds as appropriate. Bonds and other debt obligations issued by or on behalf of the association are not to be considered "state bonds" and shall not be an obligation of the state.

(3) The state hereby covenants with holders of bonds issued pursuant to this chapter that the state will not limit, alter or deny the duties and obligations of this chapter, and of the association and the commissioner as established by this chapter, necessary to fulfill the terms of any agreements with bondholders, or in any way impair the rights and remedies of such bondholders as long as any such bonds remain outstanding unless adequate provision has been made for the payment of such bonds pursuant to the documents authorizing the issuance of such bonds.

HISTORY: Laws, 2007, ch. 425, § 21, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 10, eff from and after July 1, 2019.

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.' "

§ 83-34-33. Surcharge for excess covered event losses on all property and casualty premiums; issuance of bonds to pay claims losses; exempted premiums; purpose of certain surcharges to be designated and specifically identified; licensed insurers and agents to collect and remit surcharges; setting and adjustment of surcharge percentage; cessation of surcharge.

(1) When the association knows or has reason to believe that (a) it has or will incur losses from a covered event that exceeds available surplus, reinsurance, recoupable or nonrecoupable assessments and other reasonably available assets of the association, such that one or more bond issues or other financing, or both, will be necessary to pay claims losses and other related expenses, or (b) the association has an excess deficit that cannot be reasonably resolved by income available to the association above the minimum reserve, then the association shall immediately give notice to the commissioner and request that the commissioner implement an excess deficit surcharge on all property and casualty insurance premiums for insurance for property and operations in this state designed to recover to the association the amount of all such bonds and other indebtedness resulting from the covered event, or other deficit.

(2) All such bonds and loans are secured by the power and duty of the commissioner to implement surcharges against all property and casualty insurance premiums for insurance for property and activities in this state sufficient to repay the bonds or loans, or both.

(3) If any of the bonds remain unsold sixty (60) days after issuance, the commissioner shall require all assessable insurers to purchase the bonds, which purchased bonds shall be treated as admitted assets; each assessable insurer shall be required to purchase that percentage of the unsold portion of the bond issue that equals the assessable insurer's current percentage of participation. An assessable insurer shall not be required to purchase the bonds to the extent that the commissioner determines that the purchase would endanger or impair the solvency of the insurer. The bonds must be in a form approved by the commissioner. With approval of the commissioner, the association may issue bonds or incur other indebtedness to retire or consolidate bonds as appropriate. Bonds and other debt obligations issued by or on behalf of the association are not to be considered "state bonds" and shall not be an obligation of the state.

(4) At such time as the commissioner can reasonably estimate the amount of bonds or indebtedness, or both, necessitated by a covered event, and in no event more than ninety (90) days from the notice given by the association, the commissioner shall have the duty and the power to implement an excess deficit surcharge on all property and casualty insurance premiums for insurance for property and activities in this state. "Premiums" includes premiums for

policies issued by or for the association and by or for the Mississippi Residential Property Insurance Underwriting Association. "Premiums" shall not include premiums for workers' compensation coverage, premiums for medical malpractice liability coverage including medical malpractice liability coverage issued by companies created under Section 83-47-1 et seq., nor any premiums for coverage by insurance pools or plans administered by or through the State of Mississippi.

(5) If the excess deficit surcharge is designed to repay bonds, it shall be designated as such and all funds recovered from the excess deficit surcharge shall be used for repayment of the bonds for which it was implemented, until such time as the bonds have been paid or redeemed.

(6) If the excess deficit surcharge is designed to repay a specific indebtedness incurred for losses from a specific covered event, it shall be designated as such and all funds recovered from the excess deficit surcharge shall be used for repayment of the indebtedness for which it was implemented, until such time as the indebtedness has been paid or redeemed.

(7) Such excess deficit surcharge shall be specifically identified on either the premium statements or the policy declarations pages or other appropriate policy forms as relating to the specific covered event losses or bonds or indebtedness for which it was implemented. The commissioner shall name each such excess deficit surcharge so that it can be uniformly identified by insurers and agents.

(8) The excess deficit surcharge shall be a percentage of the total policy premium but the excess deficit surcharge shall not be considered premium and is not subject to premium taxes or commissions. However, failure to pay the excess deficit surcharge shall be treated the same as failure to pay premium. "Total policy premium" includes taxes and commissions.

(9) The commissioner shall implement an appropriate excess deficit surcharge percentage sufficient to recover the amount necessary for repayment of bonds and indebtedness necessitated by a covered event, or the resolution of other deficit, as applicable. If at any time such surcharge shall be insufficient, the commissioner shall increase the excess deficit surcharge as necessary and appropriate. The commissioner shall cease excess deficit surcharges as he determines appropriate funds have been collected. However, the commissioner shall endeavor to apply excess deficit surcharges on a one-year basis in order to promote consistency, nondiscrimination and fairness among policyholders purchasing or renewing insurance during that year. Any collections in excess of the amounts needed shall be assets of the association for investment and other uses.

(10) Each licensed insurer issuing insurance for property and casualty risks in the state and each agent placing insurance through nonadmitted insurers, shall collect the excess deficit surcharges established by the commissioner under the authority of this section. Funds collected by such licensed insurers and agents placing insurance through nonadmitted insurers as excess deficit surcharges authorized by this section shall be collected and held in trust and shall be fully remitted to the association on a quarterly basis with forms

providing appropriate information as designed by the association. Insurers and agents shall remit such funds to the association within twenty (20) days after the end of each quarter. At such time the insurers and agents shall further remit to the association all interest earned on the excess deficit surcharge funds.

(11) The association and the commissioner are both specifically given the power to audit licensed insurers and agents placing insurance through nonadmitted insurers to confirm the accuracy of remittances of excess deficit surcharges at the expense of the licensed insurers and agents.

(12) The commissioner has the duty and power to adjust the percentage of any excess deficit surcharge previously established as he finds appropriate taking into consideration any relevant factors, including, but not limited to, consolidation or replacement of bonds, any additional indebtedness resulting from a covered event, the rate of recovery, anticipated length of total recovery, and impact of other covered events; however, the commissioner shall not reduce the amount of excess deficit surcharges implemented and designated to pay or redeem bonds, or other indebtedness below the amount necessary to timely pay or redeem such bonds, or other indebtedness.

(13) When the association knows or has reason to believe that excess deficit surcharges authorized by this section previously established by the commissioner will be insufficient to timely pay or redeem bonds or indebtedness, the association shall immediately give notice to the commissioner. The commissioner shall alter such excess deficit surcharge as necessary to timely pay or redeem bonds or pay other indebtedness.

(14) The association shall report quarterly to the commissioner providing all financial information for each excess deficit surcharge authorized by this section, including:

(a) The original and current outstanding indebtedness of all bonds and loans;

(b) Total excess deficit surcharge funds recovered to date; and

(c) Any information requested by the commissioner.

(15) The commissioner may request, and the association shall provide, on an immediate basis to the commissioner any financial information or other information concerning any excess deficit surcharge. This section shall not limit the reporting requirements provided by Section 83-34-25.

HISTORY: Laws, 2007, ch. 425, § 22, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 11, eff from and after July 1, 2019.

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.' "

§ 83-34-35. Commissioner to approve association rates at least adequate to fund annual reinsurance above a certain reserve.

In order to avoid or lessen the possibility and amount of excess deficit surcharges authorized by this chapter, the commissioner shall approve rates for policies issued by the association at least adequate to fund annual reinsurance above a self-insured retention of One Hundred Million Dollars ($100,000,000.00) that, combined with any readily available reserves of the association, is sufficient to cover at least the probable maximum losses from a storm expected to occur once every one hundred (100) years as predicted by a model or method approved by the commissioner for the properties insured by the association at the time the reinsurance was negotiated. The amount of reinsurance in the foregoing rate adequacy requirement shall increase every two (2) years by increasing the probable maximum loss by five (5) years, until such time as the probable maximum loss insured is for a storm expected to occur every one hundred fifty (150) years. The commissioner may approve rates in excess of the minimums required by this section as consistent with his duties and the insurance laws of the State of Mississippi. Any self-insured retention related to the purchase of reinsurance shall be subject to the prior approval of the commissioner.

HISTORY: Laws, 2007, ch. 425, § 23, eff from and after passage (approved Mar. 22, 2007); Laws, 2019, ch. 450, § 12, eff from and after July 1, 2019.

Editor's Notes — Laws of 2007, ch. 425, § 1 provides:
"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.' "

§ 83-34-37. Mississippi Windstorm Underwriting Association Reinsurance Assistance Fund created; purpose; use of funds; reports.

(1)(a) There is created in the State Treasury a special fund to be designated as the "Mississippi Windstorm Underwriting Association Reinsurance Assistance Fund." The fund shall consist of monies deposited therein as provided under Section 83-34-39, monies appropriated by act of the Legislature and monies from any other source designated for deposit into such fund. Unexpended amounts remaining in the fund at the end of a fiscal year shall not lapse into the State General Fund, and any interest earned or investment earnings on amounts in the fund shall be deposited to the credit of the fund; however, any monies in excess of Fifty Million Dollars ($50,000,000.00) remaining in the fund at the end of a fiscal year that have not been appropriated shall lapse into the State General Fund.

(b) Monies in the special fund may be used by the Department of Insurance, upon appropriation by the Legislature, only for the purpose of assisting the Mississippi Windstorm Underwriting Association in defraying expenses and costs for reinsurance under Section 83-34-1 et seq. The association may use any such funds received from the Department of Insurance for the sole purpose of defraying expenses and costs for reinsurance. Monies in the fund used for the purposes described in this paragraph (b) shall be in addition to other funds available from any other source for such purposes.

(c) Monies in the special fund may not be used, expended or transferred for any other purpose except upon amendment to this section by a bill enacted by the Legislature with a vote of not less than two-thirds (⅔) of the members of each house present and voting.

(2)(a) The Commissioner of Insurance shall file a report with the Joint Legislative Budget Committee not later than September 1 of each year, recommending the amount of assistance, if any, needed by the Mississippi Windstorm Underwriting Association for reinsurance expenses and costs. The Commissioner of Insurance also shall provide a copy of the report to the Attorney General and the Executive Director of the Mississippi Development Authority.

(b) The Mississippi Windstorm Underwriting Association shall prepare and file detailed reports with the Clerk of the House of Representatives, Secretary of the Senate, Commissioner of Insurance, Attorney General and Executive Director of the Mississippi Development Authority regarding the receipt and expenditure of monies by the association under this section.

HISTORY: Laws, 2007, ch. 425, § 2, eff from and after passage (approved Mar. 22, 2007).

Editor's Notes — Section 83-34-39, referenced in (1)(a), was repealed by its own terms, effective from and after July 1, 2010.

Laws of 2007, ch. 425, § 1 provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Economic Growth and Redevelopment Act of 2007.' "

§ 83-34-39. Repealed.

Repealed by its own terms, eff from and after July 1, 2010.

§ 83-34-39. [Laws, 2007, ch. 425, § 3, eff from and after passage (approved March 22, 2007).]

Editor's Notes — Former § 83-34-39 related to the deposit of monies into Mississippi Windstorm Underwriting Association Reinsurance Assistance Fund.

CHAPTER 35.

UNDERWRITING ASSOCIATION [REPEALED]

Sec.
83-35-1 through 83-35-31. Repealed.
83-35-33. Repealed.

§§ 83-35-1 through 83-35-31. Repealed.

Repealed by Laws, 1987, ch. 459, § 18, eff from and after December 31, 1988.

§ 83-35-1. [Codes, 1942, § 5234-101; Laws, 1970, ch 451, § 1; Laws, 1971, ch. 507, § 1; Laws, 1975, ch. 390, § 1; Laws, 1980, ch 364, § 1].

§ 83-35-3. [Codes, 1942, § 5234-102; Laws, 1970, ch. 451, § 2; Laws, 1971, ch. 507, § 2; Laws, 1974, ch. 316; Laws, 1975, ch. 390, § 2; Laws, 1980, ch. 364, § 2; Laws, 1987, ch. 422, § 52].

§ 83-35-5 through § 83-35-11. [Codes, 1942, §§ 5234-103 to 5234-106; Laws, 1970, ch. 451, §§ 3-6; Laws, 1971, ch 507, §§ 3-6; Laws, 1975, ch. 390, §§ 3-6; Laws, 1980, ch. 364, §§ 3-6].

§ 83-35-13. [Codes, 1942, § 5234-107; Laws; 1970, ch 451, § 7; Laws, 1971, ch. 507, § 7; Laws, 1975, ch. 390, § 7; Laws, 1980, ch. 364, § 7; Laws, 1987, ch. 422, § 53].

§ 83-35-15. [Codes, 1942, § 5234-108; Laws; 1970, ch 451, § 8; Laws, 1971, ch. 507, § 8; Laws, 1975, ch. 390, § 8; Laws, 1980, ch. 364, § 8; Laws, 1987, ch. 459, § 17].

§ 83-35-17 through § 83-35-31. [Codes, 1942, § 5234-109 to 5234-116; Laws, 1970, ch 451, §§ 9-16; Laws, 1971, ch. 507, §§ 9-16; Laws, 1975, ch. 390, §§ 9-16; Laws, 1980, ch. 364, § 9-16].

Editor's Notes — Former §§ 83-35-1 thru 83-35-31 contained provisions applicable to fire and extended coverage insurance in the coast area of Mississippi and educational properties throughout the State of Mississippi. For current fire insurance provisions, see §§ 83-13-1 et seq.

§ 83-35-33. Repealed.

Repealed by Laws 1985, ch. 528, § 17, eff from and after July 1, 1985.

§ 83-35-33. [Codes, 1942, § 5834-119; Laws, 1971, ch. 507, § 19; Laws, 1975, ch. 390, § 17; Laws, 1980, ch. 364, § 17]

Editor's Notes — Former § 83-35-33 provided for the repeal of §§ 83-35-1 through 83-35-31 on July 1, 1985.

CHAPTER 36.

JOINT UNDERWRITING ASSOCIATION FOR MEDICAL MALPRACTICE INSURANCE

Sec.
83-36-1 through 83-36-27. Repealed.
83-36-29. Repeal of Sections 83-36-1 through 83-36-27.
83-36-31. Authority of commissioner to close accounts established under this chapter; disposition of funds; release of liability of fund trustees.

§§ 83-36-1 through 83-36-27. Repealed.

Repealed by Laws, 1997, ch. 406, § 15 [§ 83-36-29], eff on July 1, 1998.

§ 83-36-1. [Laws, 1976, ch. 471, § 1; Laws, 1989, ch. 356, § 1; reenacted without change, Laws, 1997, ch. 406, § 1, eff from and after July 1, 1997].

§ 83-36-3. [Laws, 1976, ch. 471, § 2; Laws, 1987, ch. 472, § 1; Laws, 1989, ch. 356, § 2; reenacted without change, Laws, 1992, ch. 559, § 1; reenacted without change, Laws, 1997, ch. 406, § 2, eff from and after July 1, 1997].

§ 83-36-5. [Laws, 1976, ch. 471, § 3; Laws, 1987, ch. 472, § 2; Laws, 1989, ch. 356, § 3; reenacted without change, Laws, 1992, ch. 559, § 2; Laws, 1994, ch. 318, § 1; reenacted without change, Laws, 1997, ch. 406, § 3, eff from and after July 1, 1997].

§ 83-36-7. [Laws, 1976, ch. 471, § 4; Laws, 1987, ch. 472, § 3; Laws, 1989, ch. 356, § 4; reenacted without change, Laws, 1992, ch. 559, § 3; reenacted without change, Laws, 1997, ch. 406, § 4, eff from and after July 1, 1997].

§ 83-36-9. [Laws, 1976, ch. 471, § 5; Laws, 1987, ch. 472, § 4; Laws, 1989, ch. 356, § 5; reenacted without change, Laws, 1992, ch. 559, § 4; reenacted without change, Laws, 1997, ch. 406, § 5, eff from and after July 1, 1997].

§ 83-36-11. [Laws, 1976, ch. 471, § 6; Laws, 1987, ch. 472, § 5; reenacted without change, Laws, 1992, ch. 559, § 5; reenacted without change, Laws, 1997, ch. 406, § 6, eff from and after July 1, 1997].

§ 83-36-13. [Laws, 1976, ch. 471, § 7; Laws, 1987, ch. 472, § 6; reenacted without change, Laws, 1992, ch. 559, § 6; reenacted without change, Laws, 1997, ch. 406, § 7, eff from and after July 1, 1997].

§ 83-36-15. [Laws, 1976, ch. 471, § 8; reenacted without change, Laws, 1997, ch. 406, § 8, eff from and after July 1, 1997].

§ 83-36-17. [Laws, 1976, ch. 471, § 9; Laws, 1987, ch. 472, § 7; reenacted without change, Laws, 1992, ch. 559, § 7; reenacted without change, Laws, 1997, ch. 406, § 9, eff from and after July 1, 1997].

§ 83-36-19. [Laws, 1976, ch. 471, § 10; Laws, 1987, ch. 472, § 8; reenacted without change, Laws, 1992, ch. 559, § 8; reenacted without change, Laws, 1997, ch. 406, § 10, eff from and after July 1, 1997].

§ 83-36-21. [Laws, 1976, ch. 471, § 11; Laws, 1987, ch. 472, § 9; reenacted without change, Laws, 1992, ch. 559, § 9; reenacted without change, Laws, 1997, ch. 406, § 11, eff from and after July 1, 1997].

§ 83-36-23. [Laws, 1976, ch. 471, § 12; Laws, 1987, ch. 472, § 10;

reenacted without change, Laws, 1992, ch. 559, § 10; reenacted without change, Laws, 1997, ch. 406, § 12, eff from and after July 1, 1997].

§ 83-36-25. [Laws, 1976, ch. 471, § 13; Laws, 1987, ch. 472, § 11; reenacted without change, Laws, 1992, ch. 559, § 11; reenacted without change, Laws, 1997, ch. 406, § 13, eff from and after July 1, 1997].

§ 83-36-27. [Laws, 1976, ch. 471, § 14; reenacted without change, Laws, 1997, ch. 406, § 14, eff from and after July 1, 1997].

Editor's Notes — Former § 83-36-1 related to the legislative purpose of provisions regarding the joint underwriting association for medical malpractice insurance.

Former § 83-36-3 related to definitions for provisions regarding the joint underwriting association for medical malpractice insurance.

Former § 83-36-5 related to the creation and conditions for the joint underwriting association for medical malpractice insurance.

Former § 83-36-7 related to directors of the joint underwriting association for medical malpractice insurance.

Former § 83-36-9 related to plans for operation and legislative review of the joint underwriting association for medical malpractice insurance.

Former § 83-36-11 related to rates and premiums for the joint underwriting association for medical malpractice insurance.

Former § 83-36-13 related to the stabilization reserve fund and directors.

Former § 83-36-15 related to applications for coverage and issuance of policies concerning the joint underwriting association for medical malpractice insurance.

Former § 83-36-17 related to member participation in the joint underwriting association for medical malpractice insurance.

Former § 83-36-19 related to appeals of matters concerning the joint underwriting association for medical malpractice insurance.

Former § 83-36-21 related to the annual report of the joint underwriting association for medical malpractice insurance.

Former § 83-36-23 related to an annual examination of the affairs of the joint underwriting association for medical malpractice insurance.

Former § 83-36-25 related to immunity concerning certain matters handled by the joint underwriting association for medical malpractice insurance.

Former § 83-36-27 related to the rights of public officers serving as directors of the stabilization reserve fund.

§ 83-36-29. Repeal of Sections 83-36-1 through 83-36-27.

Sections 83-36-1 through 83-36-27 shall stand repealed on July 1, 1998.

HISTORY: Laws, 1992, ch. 559, § 13(1); Laws, 1997, ch. 406, § 15, eff from and after July 1, 1997.

§ 83-36-31. Authority of commissioner to close accounts established under this chapter; disposition of funds; release of liability of fund trustees.

(1) Upon thirty (30) days' notice to interested parties, the Commissioner may close any accounts established under this chapter. Any funds in the accounts or any other funds collected and received by the administrator or trustee of the temporary joint underwriting association established under Section 83-36-5 shall be paid to the State Treasurer for deposit in the State General Fund.

(2) Upon accounting to the Commissioner and disbursement of funds as provided in subsection (1) of this section, all past and present directors of the association shall be relieved from any liability concerning the funds and other provisions of this chapter.

HISTORY: Laws, 1994, ch. 318, § 2, eff from and after passage (approved March 10, 1994).

Editor's Notes — Section 83-36-5 referred to in (1), was repealed by Laws of 1997, ch. 406, § 15, eff on July 1, 1998.

CHAPTER 37.

BURIAL ASSOCIATIONS

Sec.
83-37-1. Unlawful unless organized under this chapter.
83-37-3. Method of organization.
83-37-5. Articles of incorporation; restriction on formation of new companies.
83-37-7. Foreign corporations admitted.
83-37-9. Corporate contract forms and rate schedules to be filed.
83-37-11. Classes of burial associations.
83-37-12. Buyer's guide.
83-37-13. Standard contract provisions.
83-37-15. Conditions for certain contracts.
83-37-17. Premium taxes.
83-37-19. Annual reports.
83-37-21. Privilege tax.
83-37-23. Cancellation of license.
83-37-25. Fiscal examinations.
83-37-27. Licenses issued as of March 1st; term.
83-37-29. Penalties; funding of agency expenses; deposit of monies into State General Fund.
83-37-31. Receivership.
83-37-33. Scope of this chapter.
83-37-35. Promulgation of rules and regulations regulating sale and solicitation of burial contracts; cease and desist orders.

§ 83-37-1. Unlawful unless organized under this chapter.

It shall be unlawful for any person, firm, association, church burial club or association, or corporation to engage in the business of a burial association or to make contracts in advance of death to bury or to pay the funeral expenses of any person or persons or to make contracts in advance of death to pay any person or persons a sum of money in lieu of funeral expenses except under the conditions hereafter set out.

If a church burial club or association enters into any kind of informal agreement or understanding, written or otherwise, to pay for funerals of its members and if it collects premiums, contributions, or any other funds therefor in competition with other burial associations, it shall come under the above definition of a burial association and be subject to all the provisions of this chapter. The secretary, treasurer, secretary-treasurer, or any other officer, by whatever name called, who handles the funds for the purposes set forth in this section shall be required to file annual reports, as required by Section 83-37-19, Mississippi Code of 1972; and failure to file such annual reports or knowingly making any false statement in the reports required shall be punished as provided by Section 83-37-29, Mississippi Code of 1972.

HISTORY: Codes, 1930, § 3990; 1942, §§ 5592, 5592.5; Laws, 1928, ch. 197; Laws, 1956, ch. 332, §§ 1, 2.

Cross References — Maintenance of cemetery by trust fund, see § 41-43-3.

Trust business charter exemption, see § 81-27-1.102

Exclusion of burial association from requirement of surplus in minimum amount, see § 83-19-77.

RESEARCH REFERENCES

ALR.

Validity of statutes regulating pre-need contracts for sale or furnishing of burial services and merchandise. 68 A.L.R.2d 1251.

Am. Jur.

43 Am. Jur. 2d, Insurance § 12.

CJS.

44 C.J.S., Insurance § 71.

§ 83-37-3. Method of organization.

Any person, firm, or association desiring to engage in the business above set out shall apply to the insurance commissioner of the State of Mississippi for a permit or license; file with the said commissioner a copy or statement in writing of the plan on which he or they propose to operate such business, the forms of all such contracts as he or they propose to make and enter into, the residence and post-office address of any such person, firm, or association, the rates to be charged, which rates shall in all cases be subject to the approval of the insurance commissioner except in cases where burial associations operate under a mutual benefit plan, and the names of all persons interested in such business other than members with whom contracts are made to pay burial expenses; and shall secure from the insurance commissioner of this state annually a license to engage in said business before engaging therein. Any corporation desiring to engage in the business above set out shall comply with all of the conditions of this section and, furthermore, be incorporated or admitted to do business as hereinafter provided.

HISTORY: Codes, 1930, § 3991; 1942, § 5593; Laws, 1928, ch. 197; Laws, 1932, ch. 290.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 68.

CJS.

46 C.J.S., Insurance § 1973.

§ 83-37-5. Articles of incorporation; restriction on formation of new companies.

(1) Until July 1, 1996, companies may be formed and organized to engage in the business herein mentioned with a capital stock of not less than Five Thousand Dollars ($5,000.00). The proposed incorporators, a majority of whom must be residents of the state, and not less than three (3), shall subscribe articles of incorporation in which shall be stated:

(a) The proposed corporate name of the company, which shall not so closely resemble the name of any corporation already transacting business in this state as to mislead the public or lead to confusion;

(b) The purpose for which it was formed and the business plan or principle of the operation of its business;

(c) The names, residences and official titles of all the officers who are to have and exercise the general control and management of the affairs and the funds of the corporation;

(d) The domicile of the proposed corporation;

(e) The amount of the capital stock.

The charter or articles of incorporation shall be approved by the Insurance Commissioner, and a certificate of approval shall be executed by the commissioner. The charter as thus approved shall be recorded in the Office of the Insurance Commissioner of this state and shall also be recorded in the Office of the Secretary of State.

(2) After July 1, 1996, no new companies may be formed and organized to engage in the business mentioned herein.

(3) No companies formed and organized to engage in the business herein mentioned may be sold, transferred or exchanged without prior approval of the Commissioner of Insurance. Before approval by the commissioner is granted, the commissioner shall verify and require that the company has an enforceable agreement with a duly licensed funeral service establishment pursuant to Section 73-11-55 to service the policies, contracts or certificates of the company; however, there shall be no reduction in benefits paid under the policy if the policyholder is affected by a merger or assumption and elects not to use the funeral home so designated under the assumption agreement.

HISTORY: Codes, 1930, § 3992; 1942, § 5594; Laws, 1928, ch. 197; Laws, 1996, ch. 357, § 1, eff from and after passage (approved March 18, 1996).

Editor's Notes — Laws of 1996, ch. 357, § 4, provides as follows:

"SECTION 4. The Commissioner of Insurance shall notify every Class A burial company of record as of sixty (60) days after the effective date of this act of [March 18, 1996] all the provisions of this act."

Cross References — Classes of burial associations, see § 83-37-11.

OPINIONS OF THE ATTORNEY GENERAL

A burial association whose license has been revoked by the Commissioner of Insurance can reapply for a new license. Dale, Mar. 19, 2004, A.G. Op. 04-0090.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 67 et seq.

CJS.
44 C.J.S., Insurance §§ 105-115.

§ 83-37-7. Foreign corporations admitted.

Any foreign corporation organized to engage in the business of a burial association may be admitted to do business in this state on the following conditions:

(a) It shall deposit with the Commissioner of Insurance a certified copy of its charter and a statement of its financial condition and business in such form and detail as he may require, signed and sworn to by its president and secretary or other proper officer, and shall pay for the filing of such statement the sum of Twenty Dollars ($20.00).

(b) It shall satisfy the commissioner that it is fully and legally organized under the laws of its state or government to do the business it proposes to transact and that it has a fully paid up and unimpaired capital of not less than Five Thousand Dollars ($5,000.00). After July 1, 1996, no foreign corporation organized to engage in the business of a burial association or unincorporated Class A burial association shall be admitted to do business in this state.

(c) It shall, by duly executed instrument filed in his office, constitute and appoint the Commissioner of Insurance and his successor its true and lawful attorney upon whom all process in any action or legal proceeding against it may be served, and therein shall agree that any process against it which may be served upon its attorney shall be of the same force and validity as if served on the company; and the authority thereof shall continue in force irrevocable so long as any liability of the company remains outstanding in this state. The service of such process shall be made by leaving a copy of the same in the hands or office of the commissioner. Copies of such instrument certified by the commissioner shall be deemed sufficient evidence thereof, and service upon such attorney shall be deemed sufficient service upon the principal.

(d) It shall appoint as its agent or agents in this state some resident or residents thereof other than the commissioner, such appointment to be made in writing, signed by the president and secretary or manager or general agent, and filed in the office of the commissioner, authorizing the agent to acknowledge service of process for and on behalf of the company, and consenting that service of process on the agent shall be as valid as if served upon the company, according to the laws of this state, and waiving all claim of error by reason of such service.

(e) It shall obtain from the commissioner a certificate that it has complied with the laws of the state and is authorized to make contracts authorized hereunder.

HISTORY: Codes, 1930, § 3993; 1942, § 5595; Laws, 1928, ch. 197; Laws, 1996, ch. 357, § 2, eff from and after passage (approved March 18, 1996).

Editor's Notes — Laws of 1996, ch. 357, § 4, provides as follows:

"SECTION 4. The Commissioner of Insurance shall notify every Class A burial company of record as of sixty (60) days after the effective date of this act [March 18, 1996] of all the provisions of this act."

Cross References — Service of process upon agents of trustees or attorneys in fact, see § 13-3-41.

Requirements for admission of foreign insurance companies, see §§ 83-21-1, 83-21-3.

Classes of burial associations, see § 83-37-11.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 85.

CJS.
44 C.J.S., Insurance §§ 129, 130.

§ 83-37-9. Corporate contract forms and rate schedules to be filed.

Any domestic or foreign corporation engaging in the business set forth herein shall also file with the insurance commissioner sample forms of all such contracts as it proposes to make and enter into and the rates to be charged, and shall secure from the insurance commissioner of this state annually a license to engage in said business before engaging therein, in like manner as if such corporation were a person, firm, or association as hereinabove set forth.

HISTORY: Codes, 1930, § 3994; 1942, § 5596; Laws, 1928, ch. 197.

JUDICIAL DECISIONS

1. In general.
Insurance commissioner could not cancel license on ground of refusal to accept new rate and contract form adopted by commissioner, and could not enjoin insurer's continuing in business. State ex rel. Rice v. Hartman, 179 Miss. 634, 176 So. 529, 1937 Miss. LEXIS 61 (Miss. 1937).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 68, 73.

CJS.
44 C.J.S., Insurance §§ 81-83, 392.

§ 83-37-11. Classes of burial associations.

Before engaging in said business, any such person, firm, association, or corporation, both foreign and domestic, shall deposit with the Treasurer of the State of Mississippi such securities as may be approved by the Commissioner of Insurance, consisting of certificates of deposit or bonds of the United States, of the State of Mississippi, or of any county, municipality, levee district, or road district in this state. The securities so deposited shall be not less than par value of Five Hundred Dollars ($500.00) for each One Hundred Twenty-five Thousand Dollars ($125,000.00), or fraction thereof, of face value and in-force certificates.

Any such person, firm, association, or corporation organized under this section may issue contracts or burial certificates in amounts not to exceed One Hundred Fifty Dollars ($150.00), provided said person, firm, association, or corporation deposits securities with the Treasurer of the State of Mississippi according to the schedule set out heretofore, with a minimum deposit of not less than One Thousand Dollars ($1,000.00) par value. Said person, firm, association, or corporation organized under this section may also issue contracts or burial certificates in amounts not to exceed Three Hundred Dollars ($300.00), provided said person, firm, association, or corporation deposits securities with the Treasurer of the State of Mississippi according to the schedule set out heretofore, with a minimum deposit of not less than Two Thousand Dollars ($2,000.00) par value. Said person, firm, association, or corporation organized under this section may also issue contracts or burial certificates in amounts not to exceed Four Hundred Fifty Dollars ($450.00), provided said person, firm, association, or corporation deposits securities with the Treasurer of the State of Mississippi according to the schedule set out heretofore, with a minimum deposit of not less than Three Thousand Dollars ($3,000.00) par value.

Any such person, firm, association, or corporation who prior hereto had on deposit with the Treasurer of the State of Mississippi the maximum amount of securities heretofore required shall not be required to deposit additional securities except on the net increase in liability of in-force certificates issued after January 1, 1974.

No individual benefit shall exceed the sum of Four Hundred Fifty Dollars ($450.00) unless said benefit in excess of Four Hundred Fifty Dollars ($450.00) is written on a schedule of rates approved by the State Commissioner of Insurance, and unless said contract specifically stipulates that anyone insured thereunder may receive in cash at his or her option the face value thereof; and with the further provision that any and all burial certificates in excess of Four Hundred Fifty Dollars ($450.00) shall come under and be subject to all the qualifications and all provisions of law governing life insurance contracts and policies in the State of Mississippi.

All contracts issued by a person, firm, association, or corporation of any of the above classifications will be issued in amounts of One Hundred Fifty Dollars ($150.00), Three Hundred Dollars ($300.00), or Four Hundred Fifty Dollars ($450.00) only. The provisions of this subsection shall not apply to funeral benefit certificates already in force in excess of Four Hundred Fifty Dollars ($450.00). No person, firm, association, or corporation shall write or issue a paid-up certificate.

A surety bond made by some company authorized to do business in Mississippi for an amount equal to twice the amount of securities required above may be filed with the Treasurer, after approval by the insurance department, in lieu of the other securities above referred to.

HISTORY: Codes, 1930, § 3995; 1942, § 5597; Laws, 1928, ch. 197; Laws, 1932, ch. 290; Laws, 1956, ch. 334, § 1; Laws, 1962, ch. 452; Laws, 1973, ch. 435, § 1; Laws, 1987, ch. 330; Laws, 1998, ch. 323, § 5, eff from and after July 1, 1998.

Cross References — Reserve liabilities of life insurance companies, see §§ 83-7-21 et seq.

Burial associations operating under the provisions of this section not required to pay premium taxes, see § 83-37-17.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance § 72.	44 C.J.S., Insurance §§ 121-123, 132, 133.

§ 83-37-12. Buyer's guide.

Each policy or contract or certificate issued under Section 83-37-11 shall have attached a buyer's guide which shall be developed by the Commissioner of Insurance and shall contain a definition of the burial contract, its provisions, its benefits and notice of the freedom of choice as provided by Section 83-37-13.

HISTORY: Laws, 1996, ch. 357, § 3, eff from and after passage (approved March 18, 1996).

Editor's Notes — Laws of 1996, ch. 357, § 4, provides as follows:
"SECTION 4. The Commissioner of Insurance shall notify every Class A burial company of record as of sixty (60) days after the effective date of this act [March 18, 1996] of all the provisions of this act."
Cross References — Classes of burial associations, see § 83-37-11.

§ 83-37-13. Standard contract provisions.

Contracts written under the provisions of Section 83-37-11 must first be approved by the commissioner of insurance and must be substantially in the following form and language; any variation thereof shall in no manner be less favorable to the insured than the form and language prescribed herein.

All policies written under authority of Section 83-37-11 shall contain the standard provisions hereinafter enumerated:

"STANDARD PROVISIONS"

"(1) The association will not be responsible for casket or any other funeral supplies or expenses contracted for by anyone unless authorized by the association, subject to minimum cash settlement hereinafter provided.

"(2) When this policy has been maintained in force for not less than two (2) consecutive months, there will be a grace period of thirty (30) days for the payment of any subsequent premium; and during such period of grace, the funeral benefit provided herein shall continue in force, provided all other conditions and stipulations herein contained shall have been complied with by such member or members.

"(3) This contract shall lapse, and the association shall not be liable for any benefits hereunder, when any premium payment on same is more than thirty (30) days in arrears; and in such event all premiums paid hereon shall be forfeited to the association.

"(4) If the contract is allowed to lapse, it may be reinstated by furnishing the association with satisfactory evidence that all members named hereon are in good health, and by the payment of the premiums required by the association, provided the policy is not over six (6) months in arrears. Acceptance of premium as of date of lapse shall reinstate the contract as of date premium is applied on lapse period.

"(5) No agent has the power on behalf of the association to modify this contract or to extend the time for payment of premium, the entire contract being that contained herein, together with the application thereof.

"(6) The association reserves the right to investigate within one (1) year from date of application all statements made in the application as to age or condition of health, and should any of the statements made therein be found to be false, the association's liability shall be limited to the return of all premiums paid hereon, and the policyholder shall forfeit all rights to the funeral benefits. All applicants must be in good health when this contract is delivered.

"(7) This contract shall be incontestable after one (1) year, except for nonpayment of premiums.

"(8) If death and/or burial occurs more than fifty (50) miles from any location of the funeral home named herein and should the beneficiary therefore deem it impractical for the association to service this contract, the association shall pay in cash to the member not less than fifty percent (50%) of the face value of the certificate to which the member is entitled or the full return of the premium paid by the member, not to exceed three-fourths percent (¾%) of the face value of the certificate, whichever amount is larger. Provided, however, if premium rates of not less than ten percent (10%) in excess of the rates described herein are requested by the association and approved by the commissioner, the standard provisions contained in this paragraph may provide for a cash settlement up to one hundred percent (100%) of the face value of the contract. If death and/or burial occurs within fifty (50) miles of any location of the funeral home named herein, and the member desires to use a funeral home other than the funeral home named in this contract, the association's liability shall be the full return of the premium paid by the member not to exceed the face value of the certificate.

"(9) There shall be no liability to any person or persons insured hereunder if death should occur through self-destruction or suicide, whether sane or insane, within one (1) year from date of issuance of this contract, or within one (1) year from the date of any reinstatement. In the event of death by suicide or self-destruction, no return of premium shall be due under this contract."

HISTORY: Codes, 1930, § 3995; 1942, § 5597; Laws, 1928, ch. 197; Laws, 1932, ch. 290; Laws, 1956, ch. 334, § 1; Laws, 1962, ch. 452; Laws, 1973, ch. 435, § 1, eff from and after January 1, 1974.

RESEARCH REFERENCES

ALR.

Construction and effect of contracts or insurance policies providing preneed coverage of burial expense or services. 67 A.L.R.4th 36.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 68, 70.

CJS.

44 C.J.S., Insurance §§ 388-390.

§ 83-37-15. Conditions for certain contracts.

A burial association may enter into burial insurance contracts with citizens of this state in a face amount of not less than Two Hundred Fifty Dollars ($250.00) nor more than Five Hundred Dollars ($500.00) for the funeral of any one person to be paid by any such burial association, subject to strict compliance with the following requirements as an absolute condition precedent to any such policy or contract being written or in force in this state:

(a) Such a burial association must be incorporated under the provisions of this chapter, and at least Twenty-five Thousand Dollars ($25,000.00) in capital stock paid up before the commencement of business by any such corporation may be authorized.

(b) Only contracts with uniform benefits may be written, which must be first approved by the commissioner of insurance, and such contracts may be written on a basis of payment of premiums for life or, alternatively, to be paid up in not less than fifteen (15) years after date of issuance. Contract benefits shall be limited to applying the face amount of the contract toward the retailed value of funeral merchandise and service; however, such contracts may provide for cash settlement benefits.

(c) The commissioner of insurance shall require compliance with minimum premium rates governing the payment of premiums on burial insurance contracts issued under the alternative plans provided in paragraph (b) of this section, and any such corporation willfully collecting rates less than those so prescribed shall have its license cancelled and revoked in accordance with the provisions of this chapter. For continuing to do business thereafter, such corporation shall be enjoined therefrom in a court of competent jurisdiction.

(d) The commissioner of insurance shall promulgate such rules and regulations as may be necessary or advisable in order to carry out the provisions of Sections 83-37-11 through 83-37-17 insofar as the same shall not conflict herewith, and shall make examinations as required of domestic life insurance companies.

(e) No corporation shall write or issue a paid-up certificate except as provided in the cited sections.

(f) Securities shall be deposited with the state treasurer equal to one half (½) of the capital stock of such companies and associations, and securities covering reserve liabilities shall likewise be deposited with the state treasurer in the amounts and manner as is now required of domestic life insurance companies.

HISTORY: Codes, 1930, § 3995; 1942, § 5597; Laws, 1928, ch. 197; Laws, 1932, ch. 290; Laws, 1956, ch. 334, § 1; Laws, 1962, ch. 452, eff from and after Jan. 1, 1963.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "paragraph (b) of this section" for "subsection (b) of this section" in the first sentence of (c). The Joint Committee ratified the correction at its August 10, 2022, meeting.

Cross References — Burial associations incorporated under the provisions of this section are required to pay annual premium taxes, see § 83-37-17.

RESEARCH REFERENCES

ALR.
Construction and effect of contracts or insurance policies providing preneed coverage of burial expense or services. 67 A.L.R.4th 36.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 68, 70.

CJS.
44 C.J.S., Insurance §§ 388-390.

§ 83-37-17. Premium taxes.

(1) Those burial associations operating under the provisions of Section 83-37-11 shall not be required to pay any premium taxes.

(2) Those burial associations incorporated under the provisions of Section 83-37-15 shall be required to pay premium taxes as follows:

(a) Such foreign burial insurance companies and associations of every kind and description writing burial insurance contracts under the provisions of Section 83-37-15 shall be required to pay an annual premium tax of three percent (3%) of the gross amount of premium receipts received from and on burial insurance contracts written in or covering risks located in this state.

(b) Such domestic burial insurance companies and associations of every kind and description writing burial insurance contracts under the provisions of Section 83-37-15 shall be required to pay an annual premium tax of one half (½) of the amount hereinabove levied upon foreign burial insurance companies and associations.

HISTORY: Codes, 1930, § 3995; 1942, § 5597; Laws, 1928, ch. 197; Laws, 1932, ch. 290; Laws, 1956, ch. 334, § 2; Laws, 1962, ch. 452, eff from and after Jan. 1, 1963.

RESEARCH REFERENCES

CJS.
44 C.J.S., Insurance §§ 118-120, 131, 132.

§ 83-37-19. Annual reports.

All such persons, firms, associations, or corporations shall, annually before the fifteenth day of February of each year, in accordance with the requirements of a form prepared and furnished by the commissioner of insurance for that purpose and in such detail as the commissioner shall prescribe, file with the commissioner a sworn statement of its business during the year previous, ending with December 31, showing the number of contracts in force, the number of contracts matured and unpaid, the amount of liability in force on said contracts at the end of the year, the business standing and the financial conditions of said persons, firms, associations, or corporations, and such other information as may be required by the commissioner of insurance.

HISTORY: Codes, 1930, § 3996; 1942, § 5598; Laws, 1928, ch. 197; Laws, 1932, ch. 290.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in the last sentence of the section. The word "corporations" has been substituted for "corporation." The Joint Committee ratified the correction at its July 8, 2004, meeting.

Cross References — Annual statement of insurance companies, see § 83-5-55.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 70.

CJS.
44 C.J.S., Insurance §§ 96, 128.

§ 83-37-21. Privilege tax.

When the above and foregoing provisions have been complied with by any person, firm, association or corporation, the insurance commissioner shall issue a license to such person, firm, association or corporation upon the payment to him of a privilege tax to engage in such business, according to the following schedule, to-wit:

Any person, firm, association or corporation beginning the business or having not exceeding five hundred (500) contracts	$ 50.00
Same, where contracts exceed five hundred (500) but do not exceed one thousand (1,000)	100.00
Same, where contracts exceed one thousand (1,000) but do not exceed fifteen hundred (1500)	150.00
Same, where contracts exceed fifteen hundred (1500) but do not exceed two thousand (2,000)	200.00
Same, where contracts exceed two thousand (2,000)	250.00

and the payment of said license shall exempt such person, firm, association, or corporation from any other privilege tax on account of said business. Provided, however, that nothing in this chapter shall exempt any such person, firm, association or corporation from the payment of any tax now imposed by law for conducting an undertaker's business or selling coffins. Every agent of any corporation organized or admitted to do business hereunder shall be required to obtain from the Commissioner of Insurance a perpetual agent certificate as prescribed in Sections 83-5-73 and 83-17-5, Mississippi Code of 1972, under the seal of his office showing that the company for which he or she is agent is licensed to do business in this state and that he or she is an agent of said company and duly authorized to do business for it. Every such agent on demand shall exhibit the said certificate to the person from whom he or she shall solicit contracts, and every such agent shall annually pay a privilege tax of Five Dollars ($5.00). The insurance commissioner may issue a duplicate certificate in case of loss or destruction of the original certificate and charge therefor a fee of Five Dollars ($5.00), and the insurance commissioner shall have the right to pass upon the qualifications of any such agent before issuing to him or her a license, and for good cause shall have the right to cancel such license.

Any person, firm, association or corporation liable for the privilege tax imposed herein who shall fail to procure the license therefor before beginning the business for which such privilege tax is required, or who shall fail to renew, during the month in which it is due, the license on said business for which a privilege license has theretofore been issued, shall, in each or either instance, be liable for the amount of the tax required for such business and fifty percent (50%) thereof. It is hereby made the duty of the insurance commissioner to collect the said tax and penalty, and the commissioner, or his duly authorized representative, may make immediate demand upon such person, firm, association or corporation for the payment of such tax and penalty, and proceed to collect the same as is provided by law for the collection of other privilege licenses, penalties and damages.

HISTORY: Codes, 1930, § 3997; 1942, § 5599; Laws, 1928, ch. 197; Laws, 1946, ch. 359, § 1; Laws, 1990, ch. 355, § 3, eff from and after July 1, 1990.

Cross References — Corporation franchise taxes, see §§ 27-13-1 et seq.
Privilege taxes on insurance agents, see § 27-15-87.
Privilege taxes on insurance companies, see §§ 27-15-103 et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 67, 75.

CJS.
44 C.J.S., Insurance §§ 118-120, 131, 132, 138.

§ 83-37-23. Cancellation of license.

The failure of any person, firm, association, or corporation to promptly pay or fulfill any contract in force at the time of maturity, when legally determined that the contract was in force, the failure to pay promptly when due the examination fee required, the failure to pay the license fee, privilege license when due, or penalties when assessed, the failure to fulfill any contract when services are performed by another person, firm, association, or corporation with whom the deceased or his legal representative had contracted, or the failure to adhere to the approved policy form, or to collect and retain the filed and approved rate for premium as filed in the office of the commissioner of insurance, each and all shall be grounds for the cancellation by the commissioner of insurance of its license to do business in this state.

Procedure for revocation of license under the above offenses shall be the same procedure as provided in the case of insurance agents engaging in the business of life, accident, and health insurance.

HISTORY: Codes, 1930, § 3998; 1942, § 5600; Laws, 1928, ch. 197; Laws, 1954,

ch. 311; Laws, 1962, ch. 453, §§ 1, 2, eff from and after passage (approved April 30, 1962).

JUDICIAL DECISIONS

1. In general.

The insurance commissioner has power to cancel burial insurance licenses only in cases provided by statute. State ex rel. Rice v. Hartman, 179 Miss. 634, 176 So. 529, 1937 Miss. LEXIS 61 (Miss. 1937).

The insurance commissioner is not permitted, by the controlling statutes, to withdraw permits and licenses for any other reasons. State ex rel. Rice v. Hartman, 179 Miss. 634, 176 So. 529, 1937 Miss. LEXIS 61 (Miss. 1937).

The insurance commissioner could not cancel burial insurer's current license on ground of insurer's refusal to accept new rate and contract form adopted by insurance commissioner, and hence could not enjoin insurer's continuing in business without license. State ex rel. Rice v. Hartman, 179 Miss. 634, 176 So. 529, 1937 Miss. LEXIS 61 (Miss. 1937).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 68.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance §§ 124, 135, 136.

§ 83-37-25. Fiscal examinations.

The insurance commissioner shall have full authority to examine the books, records, papers, and all other data belonging to or bearing on the business of any such person, firm, association, or corporation and may designate any practical accountant to make said examination at a reasonable per diem and expenses not to exceed the sum of One Hundred ($100.00) Dollars for any one (1) year, to be paid by such person, firm, association, or corporation. If upon examination the insurance commissioner be of the opinion that the capital stock of a domestic corporation has become impaired, or that any foreign company admitted to do business hereunder is insolvent, the commissioner may thereupon for said reason cancel its license to do business in this state.

Any person, firm, or corporation that may refuse to permit the insurance commissioner or any practical accountant designated by him to examine the books, records, papers, and all other data belonging to or bearing on the business of any such person, firm, or corporation shall have his, their, or its license canceled and revoked by the commissioner.

The insurance commissioner shall have full power in the regulation of any person, firm, or corporation, foreign or domestic, and anyone attempting to write burial certificate contracts without first having secured a license and having qualified under the provisions of statutes which govern, may be prosecuted under the provisions of Section 83-37-29.

HISTORY: Codes, 1930, § 3999; 1942, § 5601; Laws, 1928, ch. 197; Laws, 1932, ch. 290.

Cross References — Fees for examination of financial condition of foreign insurers, see § 83-1-27.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 67, 68.
14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.
44 C.J.S., Insurance §§ 124, 135, 136.

§ 83-37-27. Licenses issued as of March 1st; term.

The annual license granted under this chapter shall be dated as of the first day of March and be good for one year from date. All such persons, firms, associations, or corporations beginning the business herein described after the first day of March in any year shall pay a proportionate part of the privilege tax herein required.

HISTORY: Codes, 1930, § 4000; 1942, § 5602; Laws, 1928, ch. 197.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

CJS.
44 C.J.S., Insurance §§ 105-115, 129, 130.

§ 83-37-29. Penalties; funding of agency expenses; deposit of monies into State General Fund.

Any person, firm, association, or corporation engaging in the business herein described without first having complied with the provisions hereof, or any person who shall knowingly make any false statement in the reports required by this chapter as determined by the Commissioner of Insurance after written notice and hearing, shall be assessed a penalty for each violation of not less than Two Hundred Fifty Dollars ($250.00) nor more than Five Hundred Dollars ($500.00), and in addition thereto shall forfeit the license to do business in this state. Funds from such penalties shall be deposited with the State Treasurer to be placed in a fund designated as the "Insurance Department Fund."

From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1930, § 4001; 1942, § 5603; Laws, 1928, ch. 197; Laws, 1991, ch. 450 § 1; Laws, 2016, ch. 459, § 33, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Rules and regulations regulating sale and solicitation of burial contracts, see § 83-37-35.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 69.

CJS.
44 C.J.S., Insurance § 139.

§ 83-37-31. Receivership.

Should the insurance commissioner find that any person, firm, association, or corporation engaged in the business herein described has refused to pay any just claim or demand based on the contracts, or that he or they be unable to pay same after the claim or demand has been legally determined to be just and outstanding, or fail to comply with any of the licensing provisions of this chapter, the commissioner shall notify the Attorney General. The Attorney General shall apply to the chancery court for a receivership to wind up the business of such person, firm, association, or corporation, shall represent the interest of all claimants under such contracts, and shall have a right of action for the use and benefit of the claimants against the bond or security herein required for the full amount of all such claims, together with all necessary costs of such receivership.

HISTORY: Codes, 1930, § 4002; 1942, § 5604; Laws, 1928, ch. 197; Laws, 2001, ch. 378, § 1, eff from and after July 1, 2001.

Cross References — Authority of attorney general to prosecute suit on breach of contract, see § 7-5-37.

Procedure for receivership, see §§ 11-5-151 et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 148 et seq.

CJS.
44 C.J.S., Insurance §§ 181 et seq.

§ 83-37-33. Scope of this chapter.

This chapter shall not apply to any labor union or labor union organization, whether organized in this state or not, making contracts with its members to pay money or provide funeral expenses in the event of the death of any member or any member's family. Nor shall it apply to any duly organized fraternal order making contracts with its bona fide members to pay money or provide funeral expenses in the event of the death of any such bona fide members, provided such fraternal organization do not make such contracts for profit. Nor shall it apply to any duly organized church or church associations or societies making such contracts with its bona fide members only, and not making such contracts for profit.

HISTORY: Codes, 1930, § 4003; 1942, § 5605; Laws, 1928, ch. 197.

Cross References — Maintenance of cemetery by trust fund, see § 41-43-3.
Ownership of cemetery by religious society, see § 79-11-33.
Exemption of fraternal societies from general insurance laws, see § 83-29-7.
Issuance of cease and desist orders and conduct of hearings for violation of this section, see § 83-37-35.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 63.

§ 83-37-35. Promulgation of rules and regulations regulating sale and solicitation of burial contracts; cease and desist orders.

The Commissioner of Insurance is hereby authorized to promulgate rules and regulations to the extent necessary to regulate the sale and solicitation of burial contracts and in addition may issue a cease and desist order and conduct hearings on any association or individual who is deemed to be in violation of Section 83-37-29.

HISTORY: Laws, 1991, ch. 450 § 2, eff from and after passage (approved March 26, 1991).

CHAPTER 38.

MISSISSIPPI RESIDENTIAL PROPERTY INSURANCE UNDERWRITING ASSOCIATION LAW

Sec.
83-38-1. Purpose of chapter.
83-38-3. Definitions.
83-38-5. Mississippi Residential Property Insurance Underwriting Association.
83-38-7. Powers of association.
83-38-9. Association board of directors.
83-38-11. Benefits and obligations of association members; determination of participation.
83-38-13. Association plan of operation; approval and certification; amendment.
83-38-15. Application for coverage; forms; commission; issuance of policy; renewal.
83-38-17. Rate requirements.
83-38-19. Appeals to commissioner by persons aggrieved; related procedures; subsequent appeals to Chancery Court.
83-38-21. Availability of reports on inspections by association.
83-38-23. Nonliability of commissioner, association, or insurers for good faith statements.
83-38-25. Annual summary of association activity.
83-38-27. Examination of association affairs; public hearings; related expenses borne by association.
83-38-29. Rules and regulations.

§ 83-38-1. Purpose of chapter.

The Legislature finds that an adequate market for fire and extended coverage insurance is necessary to the economic welfare of the State of Mississippi and that without adequate and affordable insurance the orderly growth and development of the State of Mississippi is severely impeded; that insurance upon residential property in Mississippi is necessary; that while the need for such insurance is increasing, the market for such insurance is not adequate; and that the existing Mississippi Rural Risk Underwriting Association Law that provides a residual market for residential property insurance in rural areas of the state should be expanded to provide a residual market for residential property insurance in both rural areas and other areas of the state. It is the purpose of this chapter to provide a mandatory program to assure an adequate market for residential fire and extended coverage insurance in both the rural and other areas of Mississippi.

HISTORY: Laws, 1987, ch. 422, § 35; Laws, 2003, ch. 533, § 1, eff from and after July 1, 2003.

Editor's Notes — Laws of 2003, ch. 533, rewrote this chapter to create the Mississippi Residential Property Insurance Underwriting Association as the replacement for the Mississippi Rural Risk Underwriting Association in order to provide a residual market for residential property insurance in both rural areas and other areas of the State.

Cross References — Fulfillment of purpose of chapter by plan of operation proposed by association directors, see § 83-38-13.

§ 83-38-3. Definitions.

In this chapter, unless the context otherwise requires:

(a) "Essential property insurance," in all counties of the state except the coastal area as defined in paragraph (i), means insurance against direct loss to residential property as provided by a standard fire policy and extended coverage endorsement thereon, with terms, limits, deductibles, endorsements and exclusions as approved by the Mississippi Insurance Commissioner.

"Essential property insurance" in the coastal area as defined in paragraph (i) means insurance against direct loss to residential property as provided by a standard fire policy and extended coverage endorsement thereon, with terms, limits, deductibles, endorsements and exclusions as approved by the Mississippi Insurance Commissioner, except for the risks of wind and hail storm, which shall be excepted from coverage.

The Mississippi Residential Property Underwriting Association is not required to insure the risks of wind and hail storm in the coastal area as defined in paragraph (i).

For the purposes of this chapter, essential property insurance coverage shall be limited to ninety-five percent (95%) of the market value of real and personal property that is insured by the association, excluding the value of land.

(b) "Association" means the Mississippi Residential Property Insurance Underwriting Association established pursuant to the provisions of this chapter as the successor for the Mississippi Rural Risk Underwriting Association.

(c) "Plan of operation" means the plan of operation of the association approved or promulgated by the Mississippi Insurance Commissioner pursuant to the provisions of this chapter.

(d) "Insurable interest" means any lawful and substantial economic interest in the safety or preservation of property from loss, destruction or pecuniary damage.

(e) "Insurable property" means residential builder's risk and residential real property or the contents located therein, but shall not include insurance on motor vehicles, which property is determined by the association after inspection and pursuant to the criteria specified in the plan of operation, to be in an insurable condition; provided, however, any one- and two-family dwelling including, but not limited to, permanently installed manufactured housing built in substantial accordance with the local building code if applicable, which is not otherwise rendered uninsurable by reason of use, occupancy or state of repair, shall be an insurable risk within the meaning of this chapter, but neighborhood, area, location, environmental hazards beyond the control of the applicant or owner of the property shall not be considered in determining insurable condition.

(f) "Commissioner" means the Mississippi Insurance Commissioner as provided in Section 83-1-3.

(g) "Net direct premiums" means gross direct premiums, excluding reinsurance assumed and ceded, written on property in this state for residential fire and extended coverage insurance, including the fire and extended coverage components of comprehensive dwelling policies and homeowner policies but not including premiums on farm property, less return premiums upon cancelled contracts, dividends paid or credited to the policyholders or the unused or unabsorbed portion of premium deposits.

(h) "Rural areas" means all areas in the State of Mississippi designated as fire protection Class 9 or 10 by the Mississippi State Rating Bureau.

(i) "Coastal areas" means Hancock, Harrison and Jackson Counties.

HISTORY: Laws, 1987, ch. 422, § 36; Laws, 2003, ch. 533, § 2, eff from and after July 1, 2003.

Cross References — Issuance of property insurance by Mississippi Residential Property Insurance Underwriting Association so long as property meets definition of "insurable property," see § 83-38-15.

RESEARCH REFERENCES

ALR.

Condemnation proceedings as affecting insurable interest of property owner. 29 A.L.R.2d 888.

Fire insurance: insurable interest of one expecting to inherit property or take by will. 52 A.L.R.4th 1273.

What constitutes "vacant land" within meaning of liability or property insurance policy provisions. 47 A.L.R.5th 535.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 478, 479, 481, 932-977.

CJS.

44 C.J.S., Insurance §§ 254, 259-279.

Practice References.

Business Law Monographs, Volume IN2--Casualty and Liability Insurance (Matthew Bender elite Products).

Insuring Real Property (Matthew Bender Elite Products).

New Appleman on Insurance: Current Critical Issues in Insurance Law (published quarterly) (LexisNexis).

§ 83-38-5. Mississippi Residential Property Insurance Underwriting Association.

The Mississippi Rural Risk Insurance Association is modified and expanded as provided in this chapter and shall hereafter be known as the Mississippi Residential Property Insurance Underwriting Association. The Mississippi Residential Property Insurance Underwriting Association shall consist of all insurers authorized to write and engaged in writing property insurance within this state on a direct basis. Every such insurer shall be a member of the association and shall remain a member of the association so long as the association is in existence, as a condition of its authority to continue to transact the business of insurance in this state.

HISTORY: Laws, 1987, ch. 422, § 37; Laws, 2003, ch. 533, § 3, eff from and after July 1, 2003.

§ 83-38-7. Powers of association.

The association, pursuant to the provisions of this chapter and the plan of operation and with respect to essential property insurance on insurable property, shall have the power on behalf of its members:

(a) To cause to be issued policies of insurance to applicants;

(b) To assume reinsurance from its members;

(c) To cede reinsurance to its members and to purchase reinsurance in behalf of its members.

HISTORY: Laws, 1987, ch. 422, § 38, eff from and after July 1, 1987.

§ 83-38-9. Association board of directors.

(1) The Board of Directors of the Mississippi Rural Risk Underwriting Association serving on July 1, 2003, shall serve as the Board of Directors of the Mississippi Residential Property Insurance Underwriting Association until such time as new directors are elected or appointed as provided in the plan of operation. The permanent board shall consist of five (5) representatives of members of the association and two (2) agents from the state. The agent board members shall be appointed annually by the Commissioner of Insurance.

(2) Members of the board shall serve without salary, but shall receive per diem compensation under Section 25-3-69 while attending to business of the association; members shall be reimbursed for travel expenses incurred in the discharge of their duties; all per diem compensation and travel reimbursement shall be approved by the board prior to being incurred.

HISTORY: Laws, 1987, ch. 422, § 39; Laws, 2003, ch. 533, § 4, eff from and after July 1, 2003.

§ 83-38-11. Benefits and obligations of association members; determination of participation.

All members of the association shall participate in its writings, expenses, profits, and losses in the proportion that the net direct premium of such member written in this state during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the association, as certified to the association by the commissioner after review of annual statements, other reports, and any other statistics the commissioner shall deem necessary to provide the information herein required and which the commissioner is hereby authorized and empowered to obtain from any member of the association.

A member shall receive credit annually for essential property insurance voluntarily written in rural and coastal areas, and its participation in the writings of the association shall be reduced in accordance with the provisions of the plan of operation.

The participation of each member in the association shall be determined annually.

HISTORY: Laws, 1987, ch. 422, § 40; Laws, 2003, ch. 533, § 5, eff from and after July 1, 2003.

§ 83-38-13. Association plan of operation; approval and certification; amendment.

(1) The directors of the association shall maintain a plan of operation to carry out the purposes of this chapter. Such plan shall grant proper credit annually to each member of the association for essential property insurance voluntarily written in the rural and coastal areas of the state, shall provide for a method of computing rates that is actuarially sound and shall provide for the efficient, economical, fair and nondiscriminatory administration of the association. The plan may include a method for assessment of all members for expenses necessary to operate the association, selection of directors from the members of the association, assessment of members to defray losses and expenses, underwriting standards, procedures for the acceptance and cession of reinsurance, procedures for determining the amount of insurance to be provided to specific risks, time limits and procedures for processing applications for insurance, and other provisions as may be deemed necessary by the commissioner to carry out the purposes of this chapter.

(2) The plan of operation and any proposed amendments thereto are subject to review and approval by the commissioner to fulfill the purposes provided by Section 83-38-1. In the review of the plan, the commissioner may consult with the directors of the association and may seek any further information which is necessary for a decision. If the commissioner approves the plan, the commissioner shall certify such approval to the directors, and the plan shall become effective after such certification. If the commissioner disapproves all or any part of the plan of operation, the commissioner shall return the same to the directors with a written statement of the reasons for disapproval and any recommendations. The directors may alter the plan in accordance with the commissioner's recommendation or, within thirty (30) days from the date of disapproval, may return a new plan to the commissioner. Should the directors fail to submit a proposed plan of operation which is acceptable to the commissioner, or accept the recommendation of the commissioner within thirty (30) days after disapproval of the plan, the commissioner shall promulgate and place into effect a plan of operation certifying the same to the directors of the association. A plan promulgated by the commissioner shall take effect thirty (30) days after certification to the directors.

(3) The directors of the association, subject to the approval of the commissioner, may amend the plan of operation at any time. The commissioner may review the plan of operation at any time deemed expedient or prudent, but not less than once in each calendar year.

HISTORY: Laws, 1987, ch. 422, § 41; Laws, 2003, ch. 533, § 6, eff from and after July 1, 2003.

Cross References — Creation and functions of board of directors, see § 83-38-9.

§ 83-38-15. Application for coverage; forms; commission; issuance of policy; renewal.

(1) Any person having an insurable interest in insurable property is entitled to apply to the association for such coverage and for an inspection of the property. Such application may be made on behalf of the applicant by a broker or agent licensed in Mississippi authorized by him. Every such application shall be submitted on forms prescribed by the association after consultation with the commissioner. The application shall contain an inquiry as to whether there are unpaid premiums due from the applicant for fire insurance on the property.

The commission paid to the submitting broker or agent shall be equal to ten percent (10%) of the premium collected.

(2) If the association determines that the property is insurable and that there is no unpaid premium due from the applicant for prior insurance on the property, the association, upon receipt of the premium or such portion thereof as is prescribed in the plan of operation, shall cause to be issued a policy of essential property insurance for a term of one (1) year. Any policy issued pursuant to the provisions of this section shall be renewed annually so long as:

(a) The property continues to meet the definition of "insurable property" set forth in Section 83-38-3(e);

(b) A properly completed application for renewal shall have been received by the association on or before the date of renewal; and

(c) Property premiums have been received by the association on or before the date of renewal.

(3) If the association for any reason denies an application and refuses to cause to be issued an insurance policy on insurable property to any applicant, or takes no action on an application within the time prescribed in the plan of operation, the applicant may appeal to the commissioner. The commissioner or a member of the staff of the Insurance Department designated by the commissioner, after reviewing the facts, may determine if the association acted in accordance with the law and the plan of operation. In carrying out the duties pursuant to this section, the commissioner may request, and the association shall provide, any information deemed necessary to a determination concerning the reasons for the denial or delay of the application.

HISTORY: Laws, 1987, ch. 422, § 42; Laws, 2003, ch. 533, § 7, eff from and after July 1, 2003.

§ 83-38-17. Rate requirements.

The forms, rates, rating plans, and rating rules applicable to the insurance written by the association shall be those approved for use of the association by the commissioner. Surcharges may be used as approved by the commissioner. Rates shall be actuarially sound and nondiscretionary as to the same class of risk.

HISTORY: Laws, 1987, ch. 422, § 43; Laws, 2003, ch. 533, § 8, eff from and after July 1, 2003.

§ 83-38-19. Appeals to commissioner by persons aggrieved; related procedures; subsequent appeals to Chancery Court.

Any person insured pursuant to this chapter, or his representative, or any affected insurer who may be aggrieved by an act, ruling, or decision of the association, within thirty (30) days after such ruling, is entitled to appeal to the commissioner. A hearing before the commissioner upon such appeal shall be in accordance with the procedures promulgated by the commissioner. The commissioner is authorized to appoint a member of the Insurance Department staff for the purpose of hearing such appeals, and a ruling based upon such hearing shall have the same effect as if heard by the commissioner. All persons or insureds aggrieved by any order or decision of the commissioner may appeal, within thirty (30) days of such order or decision to the Chancery Court of the First Judicial District of Hinds County.

HISTORY: Laws, 1987, ch. 422, § 44, eff from and after July 1, 1987.

§ 83-38-21. Availability of reports on inspections by association.

All reports of inspection performed by or on behalf of the association are available to the members of the association, applicants, agents, brokers and the commissioner.

HISTORY: Laws, 1987, ch. 422, § 45; Laws, 2003, ch. 533, § 9, eff from and after July 1, 2003.

§ 83-38-23. Nonliability of commissioner, association, or insurers for good faith statements.

There shall be no liability on the part of and no cause of action of any nature shall arise against the Commissioner of Insurance or any of his staff, the association or its directors, agents or employers, or against any participating insurer for any inspections made hereunder or any statements made in good faith by them in any reports or communications concerning risks submitted to the association, or at any administrative hearings conducted in connection therewith under the provisions of this chapter.

HISTORY: Laws, 1987, ch. 422, § 46, eff from and after July 1, 1987.

§ 83-38-25. Annual summary of association activity.

The association shall file in the office of the commissioner on or before March 1 of each year a statement which summarizes the transactions, conditions, operations and affairs of the association during the preceding fiscal year ending December 31. The statement shall contain such matters and information and be in a form prescribed by the commissioner. At any time the commissioner may require the association to furnish any additional information with respect to its transactions or any other matter which the commissioner deems to be material in evaluating the operation and experience of the association.

HISTORY: Laws, 1987, ch. 422, § 47, eff from and after July 1, 1987.

§ 83-38-27. Examination of association affairs; public hearings; related expenses borne by association.

The commissioner may make an examination into the affairs of the association at any time. In undertaking such examination, the commissioner is empowered to hold a public hearing. The expenses of such examination shall be borne and paid by the association.

HISTORY: Laws, 1987, ch. 422, § 48, eff from and after July 1, 1987.

§ 83-38-29. Rules and regulations.

The commissioner is empowered to make reasonable rules and regulations, not inconsistent with law, to enforce, carry out, and make effective the provisions of this chapter.

HISTORY: Laws, 1987, ch. 422, § 49, eff from and after July 1, 1987.

CHAPTER 39.

BAIL BONDS AND BONDSMEN

Sec.
83-39-1. Definitions.
83-39-3. Individual license required; funding of agency expenses; deposit of monies into State General Fund.
83-39-5. License requirements.
83-39-7. Qualification bond; return of defendant out on bond; return of qualification bond.
83-39-8. Managing and closing business upon death of personal surety.
83-39-9. Issuance of license.
83-39-11. License fees.
83-39-13. Annual financial statement; maintenance and registration of office physically located in Mississippi municipality or county required; Bail Bond Database.
83-39-15. Grounds for denial, suspension, revocation, and refusal to renew license.
83-39-17. Hearing.
83-39-19. Appeals.
83-39-21. Judicial proceeding in lieu of departmental hearing.
83-39-23. Notice to sheriff and judicial officials.
83-39-25. Maximum premium, commission or fee; processing fee; holding collateral to insure payment of premium or indemnify for losses.
83-39-27. Prohibited activities.
83-39-29. Penalties.
83-39-30. Prohibited activities; illegal business referrals.
83-39-31. Fee on appearance bonds and recognizances; additional assessment on bail bonds to be deposited into Victims of Domestic Violence Fund.

§ 83-39-1. Definitions.

The following terms when used in this chapter shall have the following meanings:

(a) "Department" means the Department of Insurance.

(b) "Commissioner" means the Commissioner of Insurance.

(c) "Insurer" means any domestic or foreign insurance corporation or association engaged in the business of insurance or suretyship which has qualified to transact surety or casualty business in this state.

(d) "Professional bail agent" means any individual who shall furnish bail, acting as a licensed personal surety agent or as a licensed limited surety agent representing an insurer as defined by this chapter. The above definition shall not include, and this chapter does not apply to, any individual who is not licensed under this chapter who acts as personal surety in instances where there is no compensation charged or received for such service.

(e) "Soliciting bail agent" means any person who, as an agent or employee of a professional bail agent, or as an independent contractor, for compensation or otherwise, shall solicit, advertise or actively seek bail bond business for or on behalf of a professional bail agent and who assists the professional bail agent in presenting the defendant in court when required or assists in the apprehension and surrender of the defendant to the court or keeps the defendant under necessary surveillance.

(f) "Bail enforcement agent" means a person who assists the professional bail agent in presenting the defendant in court when required, or who assists in the apprehension and surrender of the defendant to the court or who keeps the defendant under necessary surveillance. Nothing herein shall affect the right of professional bail agents to have counsel or to ask assistance of law enforcement officers.

(g) "Limited surety agent" means any individual who is appointed by an insurer by power of attorney to execute or countersign bail bonds in connection with judicial proceedings, and who is duly licensed by the commissioner to represent such insurer for the restricted lines of bail, fidelity and surety, after successfully completing a limited examination by the department for the restricted lines of business.

(h) "Personal surety agent" means any individual who, having posted the necessary qualification bond with the commissioner as required by Section 83-39-7, and duly licensed by the commissioner, may execute and sign bail bonds in connection with judicial proceedings. All new personal surety agents licensed after July 1, 1994, shall complete successfully a limited examination by the department for the restricted lines of business.

(i) "Surety" means the insurer or the personal surety agent guaranteeing the bail bond and for the purpose of process does not mean the agent of such insurer or personal surety agent.

(j) "Bail" means the use of money, property or other security to cause the release of a defendant from custody and secure the appearance of a defendant in criminal court proceedings, or the monitoring or supervision of defendants who are released from custody on recognizance, parole or probation, except when such monitoring or supervision is conducted after conviction, sentencing or other adjudication and solely by public employees.

HISTORY: Codes, 1942, § 8745-01; Laws, 1968, ch. 341, § 1; Laws, 1994, ch. 495, § 1; Laws, 2000, ch. 384, § 1; Laws, 2003, ch. 452, § 1; Laws, 2010, ch. 466, § 1, eff from and after July 1, 2010.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

JUDICIAL DECISIONS

ANALYSIS

1. State regulation.
2. Service of process.

1. State regulation.

While bail bondsmen licenses were governed by state law and county sheriffs could not revoke a license issued by the state under the scheme of Miss. Code Ann. §§ 83-39-1 et seq., where a state judge had held that county sheriffs had no discretion to suspend bond-writing rights, the district court's summary judgment to defendant county on a due process claim was reversed; defendant sheriff's decision to remove plaintiff bonding agents from the approved list could be the basis of the county's due process liability based on policy and custom. Hampton Co. Nat'l Sur.

LLC v. Tunica County Miss., 543 F.3d 221, 2008 U.S. App. LEXIS 20068 (5th Cir. Miss. 2008).

2. Service of process.

Service of process on a bail bondsman's agent was insufficient when defendant failed to appear at trial because by statute an agent could not be served to achieve service of process on a bail bondsman. However, because the bail bondsman remained as surety for defendant, reversal and remand were appropriate for proper process of scire facias to be had on the bail bondsman, at which point the trial court could proceed in accordance with the applicable law. Newell v. State, 282 So. 3d 655, 2019 Miss. App. LEXIS 335 (Miss. Ct. App. 2019).

OPINIONS OF THE ATTORNEY GENERAL

A scire facias may be personally served on a limited surety agent, and that process will be binding on the insurer represented by that agent. Johnson, November 6, 1998, A.G. Op. #98-0672.

A bail enforcement agent may be employed by more than one professional bail agent, however, the agent's license should indicate each professional bail agent by whom they are employed. Beshears, May 28, 2004, A.G. Op. 04-0219.

RESEARCH REFERENCES

Am. Jur.

74 Am. Jur. 2d, Suretyship § 202.

3A Am. Jur. Legal Forms 2d, Bail and Recognizance §§ 35:2 et seq. (sureties).

CJS.

44 C.J.S., Insurance § 19.

§ 83-39-3. Individual license required; funding of agency expenses; deposit of monies into State General Fund

(1) No person shall act in the capacity of professional bail agent, soliciting bail agent or bail enforcement agent, as defined in Section 83-39-1, or perform any of the functions, duties or powers of the same unless that person shall be qualified and licensed as provided in this chapter. The terms of this chapter shall not apply to any automobile club or association, financial institution, insurance company or other organization or association or their employees who execute bail bonds on violations arising out of the use of a motor vehicle by their members, policyholders or borrowers when bail bond is not the principal benefit of membership, the policy of insurance or of a loan to such member, policyholder or borrower.

(2)(a) No license shall be issued or renewed except in compliance with this chapter, and none shall be issued except to an individual. No firm, partnership, association or corporation, as such, shall be so licensed. No professional bail agent shall operate under more than one (1) trade name. A soliciting bail agent and bail enforcement agent shall operate only under the professional bail agent's name. No license shall be issued to or renewed for any person who has ever been convicted of a crime that the commissioner finds directly relates to the duties and responsibilities of the business of a professional bail agent, soliciting bail agent, or bail enforcement agent, including, but not limited to, any felony that involves an act of fraud, dishonesty, or a breach of trust, or money laundering. No license shall be issued to any person who is under twenty-one (21) years of age. No person engaged as a law enforcement or judicial official or attorney shall be licensed hereunder. A person who is employed in any capacity at any jail or corrections facility that houses state, county or municipal inmates who are or may be eligible for bail, whether the person is a public employee, independent contractor, or the employee of an independent contractor, may not be licensed under this section.

(b)(i) No person who is a relative of either a sworn state, county or municipal law enforcement official or judicial official, or an employee, independent contractor or the contractor's employee of any police department, sheriff's department, jail or corrections facility that houses or holds federal, state, county or municipal inmates who are or may be eligible for bail, shall write a bond in the county where the law enforcement entity or court in which the person's relative serves is located. "Relative" means a spouse, parent, grandparent, child, sister, brother, or a consanguineous aunt, uncle, niece or nephew. Violation of this prohibition shall result in license revocation.

(ii) No person licensed under this chapter shall act as a personal surety agent in the writing of bail during a period he or she is licensed as a limited surety agent, as defined herein.

(iii) No person licensed under this chapter shall give legal advice or a legal opinion in any form.

(3) The department is vested with the authority to enforce this chapter. The department may conduct investigations or request other state, county or local officials to conduct investigations and promulgate such rules and regulations as may be necessary for the enforcement of this chapter. The department may establish monetary fines and collect such fines as necessary for the enforcement of such rules and regulations. All fines collected shall be deposited in the Special Insurance Department Fund for the operation of that agency.

(4)(a) Each license issued hereunder shall expire biennially on the last day of September of each odd-numbered year, unless revoked or suspended prior thereto by the department, or upon notice served upon the commissioner by the insurer that the authority of a limited surety agent to act for or on behalf of such insurer had been terminated, or upon notice served upon the commissioner that the authority of a soliciting bail agent or bail enforcement agent had been terminated by such professional bail agent.

(b) A soliciting bail agent or bail enforcement agent may, upon termination by a professional bail agent or upon his cessation of employment with a professional bail agent, be relicensed without having to comply with the provisions of subsection (7)(a) and (b) of this section, if he has held a license in his respective license category within ninety (90) days of the new application, meets all other requirements set forth in Section 83-39-5 and subsection (7)(b) of this section, and notifies the previous professional bail agent in writing that he is submitting an application for a new license.

(5) The department shall prepare and deliver to each licensee a license showing the name, address and classification of the licensee, and shall certify that the person is a licensed professional bail agent, being designated as a

personal surety agent or a limited surety agent, a soliciting bail agent or a bail enforcement agent. In addition, the license of a soliciting bail agent or bail enforcement agent, shall show the name of the professional bail agent and any other information as the commissioner deems proper.

(6) The commissioner, after a hearing under Section 83-39-17, may refuse to issue a privilege license for a soliciting bail agent to change from one (1) professional bail agent to another if he owes any premium or debt to the professional bail agent with whom he is currently licensed. The commissioner, after a hearing under Section 83-39-17, shall refuse to issue a license for a limited surety agent if he owes any premium or debt to an insurer to which he has been appointed. If a license has been granted to a limited surety agent or a soliciting bail agent who owed any premium or debt to an insurer or professional bail agent, the commissioner, after a hearing under Section 83-39-17, shall revoke the license.

(7)(a) Before the issuance of any initial professional bail agent, soliciting bail agent or bail enforcement agent license, the applicant shall submit proof of successful completion of forty (40) hours of prelicensing education approved by the Mississippi Insurance Department unless the applicant is currently licensed under this chapter on July 1, 2014, and has maintained that license in compliance with the continuing education requirements of subsection (8) of this section. Any applicant who has met all continuing education requirements as set forth in subsection (8)(a) of this section and has been properly licensed under this chapter within ninety (90) days of submitting an application for a license shall not be subject to the prelicensing education requirement.

(b) All applicants for a professional bail agent, soliciting bail agent or bail enforcement agent license applying for an original license after July 1, 2014, shall successfully complete a limited examination by the department for the restricted lines of business before the license can be issued; however, this examination requirement shall not apply to any licensed bail soliciting agent and bail enforcement agent transferring to another professional bail agent license, any licensed bail soliciting agent applying for a bail enforcement agent license, and any licensed bail enforcement agent applying for a bail soliciting agent license. An applicant shall only be required to successfully complete the limited examination once.

(c) Beginning on July 1, 2011, in order to assist the department in determining an applicant's suitability for a license under this chapter, the applicant shall submit a set of fingerprints with the submission of an application for license. The department shall forward the fingerprints to the Department of Public Safety for the purpose of conducting a criminal history record check. If no disqualifying record is identified at the state level, the Department of Public Safety shall forward the fingerprints to the Federal Bureau of Investigation for a national criminal history record check. Fees related to the criminal history record check shall be paid by the applicant to the commissioner and the monies from such fees shall be deposited in the special fund in the State Treasury designated as the "Insurance Department Fund."

(8)(a) Before the renewal of the license of any professional bail agent, soliciting bail agent or bail enforcement agent, the applicant shall submit proof of successful completion of continuing education hours as follows:

(i) There shall be no continuing education required for the first licensure year;

(ii) Except as provided in subparagraph (i), eight (8) hours of continuing education for each year or part of a year of the two-year license period, for a total of sixteen (16) hours per license period.

(b) If an applicant for renewal failed to obtain the required eight (8) hours for each year of the license period during the actual license year in which the education was required to be obtained, the applicant shall not be eligible for a renewal license but shall be required to obtain an original license and be subject to the education requirements set forth in subsection (7). The commissioner shall not be required to comply with Section 83-39-17 in denying an application for a renewal license under this paragraph (b).

(c) The education hours required under this subsection (8) shall be approved by the Mississippi Insurance Department.

(d) The continuing education requirements under this subsection (8) shall not be required for renewal of a bail agent license for any applicant who is sixty-five (65) years of age and who has been licensed as a bail agent for a continuous period of twenty (20) years immediately preceding the submission of the application as evidenced by submission of an affidavit, under oath, on a form prescribed by the department, signed by the licensee attesting to satisfaction of the age, licensing, and experience requirements of this paragraph (d).

(9) No license as a professional bail agent shall be issued unless the applicant has been duly licensed by the department as a soliciting bail agent for a period of three (3) consecutive years immediately preceding the submission of the application. However, this subsection (9) shall not apply to any person who was licensed as a professional bail agent before July 1, 2011.

(10) A nonresident person may be licensed as a professional bail agent, bail soliciting agent or bail enforcement agent if:

(a) The person's home state awards licenses to residents of this state on the same basis; and

(b) The person has satisfied all requirements set forth in this chapter.

(11) On or before October 1, 2016, the Insurance Department shall establish a statewide Electronic Bondsmen Registry for all licenses, powers of appointment and powers of attorney requiring registration under this section. Once established, each professional bail agent, limited surety agent, bail soliciting agent, bail enforcement agent or insurance company writing bail bonds shall be required under this subsection (11) to register and maintain a record of each required license, power of appointment and power of attorney in the registry. Failure to comply with this provision will subject the agent to the penalties provided in Section 83-39-29.

(12) From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges

and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

(13) From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Codes, 1942, § 8745-02; Laws, 1968, ch. 341, § 2; Laws, 1994, ch. 495, § 2; Laws, 1997, ch. 410, § 19; Laws, 1999, ch. 497, § 1; Laws, 2001, ch. 353, § 1; Laws, 2001, ch. 563, § 1; Laws, 2006, ch. 586, § 1; Laws, 2007, ch. 501, § 3; Laws, 2008, ch. 467, § 1; Laws, 2010, ch. 466, § 2; Laws, 2011, ch. 463, § 4; Laws, 2012, ch. 394, § 1; Laws, 2013, ch. 423, § 1; Laws, 2014, ch. 479, § 1; Laws, 2016, ch. 446, § 1; Laws, 2016, ch. 459, § 34, eff from and after July 1, 2016; reenacted without change, Laws, 2018, ch. 362, § 1, eff from and after July 1, 2018.

Joint Legislative Committee Note — Section 1 of ch. 353, Laws of 2001, effective from and after July 1, 2001 (approved March 11, 2001), amended this section. Section 1 of ch. 563, Laws of 2001, effective from and after July 1, 2001 (approved April 7, 2001), also amended this section. As set out above, this section reflects the language of Section 1 of ch. 563, Laws of 2001, pursuant to Section 1-3-79, which provides that whenever the same section of law is amended by different bills during the same legislative session, and the effective dates of the sections are the same, the amendment with the latest approval date shall supersede all other amendments to the same section approved on an earlier date.

Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected an error in (8)(a) by inserting "the" preceding "license of any professional bail agent," so that "Before the renewal of license" now reads "Before the renewal of the license." The Joint Committee ratified the correction at its August 5, 2008, meeting.

Laws of 2016, ch. 446, § 4, was amended by Laws of 2018, ch. 362, § 4, to delete the July 1, 2018, repealer for this section.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "Laws of 2016, ch. 446, § 4, was amended by Laws of 2018, ch. 362, § 4, to delete the July 1, 2018, repealer for this section.

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Fee on every bond taken by bondsmen licensed under this chapter, see § 83-39-31.

JUDICIAL DECISIONS

1. Constitutionality.

Licensing requirement, Miss. Code Ann. § 83-39-3(2), violated the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution where the State failed to articulate any rationale basis for precluding all felons, regardless of the nature or age of the felony, from holding bail-agent licenses. Chunn v. State ex rel. Miss. Dep't of Ins., 156 So. 3d 884, 2015 Miss. LEXIS 36 (Miss. 2015).

OPINIONS OF THE ATTORNEY GENERAL

The term law enforcement official as used in the context of this section would include any employee of a sheriff's office, including dispatchers and jailers. The term judicial official would include all employees of any court that enforces criminal laws. Dale, April 27, 1995, A.G. Op. #95-0243.

A professional bail agent is required to obtain a license under Section 83-39-3. Any professional bondsman with a valid license may serve as a surety for an appearance bond in municipal court. Cadle, November 15, 1996, A.G. Op. #96-0791.

A professional bondsman's, with a valid license under Section 83-39-3, may be revoked or suspended for the conviction of a felony or a crime involving moral turpitude, however we are not aware of any provision that restricts a bondsman with a valid license from serving as a surety simply because he was charged with an offense and was subsequently released on bond. Cadle, November 15, 1996, A.G. Op. #96-0791.

A convicted felon cannot be issued a professional bail agent's license, although the Department of Insurance has discretion to take action against an individual who has already been licensed and then is convicted of a felony. Dale, Nov. 5, 1999, A.G. Op. #1999-0579.

For the purposes of the statute, a correctional officer is a law enforcement official and, therefore, is prohibited from obtaining a bail bondsman license. Walker, Mar. 30, 2001, A.G. Op. #01-0183.

A sheriff or court may require a bondsman to prove he has enough assets to cover all outstanding bonds written by him or his soliciting agents prior to accepting a bond from him or his soliciting agents; however, a court does not have the authority to require a licensed professional bondsman to post collateral to ensure payment on outstanding bonds. Payne, Sept. 13, 2002, A.G. Op. #02-0513.

A court does not have authority to require a bondsman to maintain an office within the city limits or to require the bondsman to maintain set business hours; however, a court may require a bondsman to provide an address and be reasonably available for service of process. Payne, Sept. 13, 2002, A.G. Op. #02-0513.

A bail enforcement agent may be employed by more than one professional bail agent, however, the agent's license should indicate each professional bail agent by whom they are employed. Beshears, May 28, 2004, A.G. Op. 04-0219.

Where the Department of Insurance has received an application for licensing as a bail agent from a person who pled guilty to a felony, but pursuant to Section 99-15-26, the court did not accept the guilty plea, there has been no conviction of a felony for purposes of Section 83-39-3(2)(a); however, Section 83-39-9 requires an applicant to submit proof of good moral character, thus, the Department may examine the behavior and conduct leading to the guilty plea and make a determination as to whether the applicant has good moral character. Dale, May 20, 2005, A.G. Op. 05-0213.

RESEARCH REFERENCES

Am. Jur.

74 Am. Jur. 2d, Suretyship § 203.

CJS.

44 C.J.S., Insurance § 138.

§ 83-39-5. License requirements.

Any person desiring to engage in the business of professional bail agent, soliciting bail agent, or bail enforcement agent in this state shall apply to the department for a license on forms prepared and furnished by the department. The application for a license, or renewal thereof, shall set forth, under oath, the following information:

(a) Full name, age, date of birth, social security number, residence during the previous five (5) years, occupation and business address of the applicant.

(b) Spouse's full name, occupation and business address.

(c) A photograph of the applicant and a full set of fingerprints for the initial application and, thereafter, as requested by the department.

(d) A statement that he is not licensed to practice law in the State of Mississippi or any other state and that no attorney or any convicted felon has any interest in his application, either directly or indirectly.

(e) Any other information as may be required by this chapter or by the department.

(f) In the case of a professional bail agent, a statement that he will actively engage in the bail bond business.

(g) In the case of a soliciting bail agent, a statement that he will be employed or used by only one (1) professional bail agent and that the professional bail agent will supervise his work and be responsible for his conduct in his work. A professional bail agent shall sign the application of each soliciting bail agent employed or used by him.

Each application or filing made under this section shall include the social security number(s) of the applicant in accordance with Section 93-11-64, Mississippi Code of 1972.

HISTORY: Codes, 1942, § 8745-03; Laws, 1968, ch. 341, § 3; Laws, 1994, ch. 495, § 3; Laws, 1997, ch. 410, § 20; Laws, 1997, ch. 588, § 71; Laws, 2007, ch. 501, § 4, eff from and after June 1, 2007.

Joint Legislative Committee Note — Section 20 of ch. 410, Laws of 1997, amended this section, effective July 1, 1997 (approved March 24, 1997). Section 71 of ch. 588, Laws of 1997, effective July 1, 1997 (approved April 24, 1997), also amended this section. As set out above, this section reflects the language of Section 71 of ch. 588, Laws of 1997, pursuant to Section 1-3-79 which provides that whenever the same section of law is amended by different bills during the same legislative session, and the effective dates of the amendments are the same, the amendment with the latest approval date shall supersede all other amendments to the same section approved on an earlier date.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Fee on every bond taken by bondsmen licensed under this chapter, see § 83-39-31.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 75.

CJS.
44 C.J.S., Insurance § 138.

§ 83-39-7. Qualification bond; return of defendant out on bond; return of qualification bond.

(1)(a) Each applicant for a professional bail agent license who acts as personal surety shall be required to post a qualification bond in the amount of Thirty Thousand Dollars ($30,000.00).

(b) The Insurance Department shall submit a report to the Senate and House of Representatives Committees on Accountability, Efficiency and

Transparency that details the amount of all bonds or undertakings that each bail bondsman has written in this state on which the bail bondsman is absolutely or conditionally liable since the Bail Bond Database was established by the department. The report shall be submitted on or before December 1, 2017. The report shall also include the number of bail bondsmen who have failed to comply with the database reporting requirements, if any, the technical issues that may have occurred since the database was established and any suggested legislation to ensure each bail bondsman's continued compliance with the database reporting requirements.

(2) The qualification bond shall be made by depositing with the commissioner the aforesaid amount of bonds of the United States, the State of Mississippi or any agency or subdivision thereof, or a certificate of deposit issued by an institution whose deposits are insured by the Federal Deposit Insurance Corporation and made payable jointly to the owner and the Department of Insurance, or shall be written by an insurer as defined in this chapter, shall meet the specifications as may be required and defined in this chapter, and shall meet such specifications as may be required and approved by the department. The bond shall be conditioned upon the full and prompt payment of any bail bond issued by such professional bail agent into the court ordering the bond forfeited. The bond shall be to the people of the State of Mississippi in favor of any court of this state, whether municipal, justice, county, circuit, Supreme or other court.

(3) If any bond issued by a professional bail agent is declared forfeited and judgment entered thereon by a court of proper jurisdiction as authorized in Section 99-5-25, and the amount of the bond is not paid within ninety (90) days, that court shall order the department to declare the qualification bond of the professional bail agent to be forfeited and the license revoked. If the bond was not forfeited correctly under Section 99-5-25, it shall be returned to the court as uncollectible. The department shall then order the surety on the qualification bond to deposit with the court an amount equal to the amount of the bond issued by the professional bail agent and declared forfeited by the court, or the amount of the qualification bond, whichever is the smaller amount. The department shall, after hearing held upon not less than ten (10) days' written notice, suspend the license of the professional bail agent until such time as another qualification bond in the required amount is posted with the department. The revocation of the license of the professional bail agent shall also serve to revoke the license of each soliciting bail agent and bail enforcement agent employed or used by such professional bail agent. In the event of a final judgment of forfeiture of any bail bond written under the provisions of this chapter, the amount of money so forfeited by the final judgment of the proper court, less all accrued court costs and excluding any interest charges or attorney's fees, shall be refunded to the bail agent or his insurance company upon proper showing to the court as to which is entitled to same, provided the defendant in such cases is returned to the sheriff of the county to which the original bail bond was returnable within eighteen (18) months of the date of such final judgment, or proof made of incarceration of the

defendant in another jurisdiction, and that a "Hold Order" has been placed upon the defendant for return of the defendant to the sheriff upon release from the other jurisdiction, the return to the sheriff to be the responsibility of the professional bail agent, then the bond forfeiture shall be stayed and remission made upon petition to the court, in the amount found in the court's discretion to be just and proper. A bail agent licensed under this chapter shall have a right to apply for and obtain from the proper court an extension of time delaying a final judgment of forfeiture if such bail agent can satisfactorily establish to the court wherein such forfeiture is pending that the defendant named in the bail bond is lawfully in custody outside of the State of Mississippi.

(4) The qualification bond may be released by the department to the professional bail personal surety agent upon an order to release the qualification bond issued by a court of competent jurisdiction, or upon written request to the department by the professional bail personal surety agent no earlier than five (5) years after the expiration date of his last license.

HISTORY: Codes, 1942, § 8745-03; Laws, 1968, ch. 341, § 3; Laws, 1994, ch. 495, § 4; Laws, 1997, ch. 410, § 21; Laws, 1998, ch. 323, § 6; Laws, 1999, ch. 399, § 1; Laws, 2000, ch. 456, § 1; Laws, 2003, ch. 351, § 1; Laws, 2004, ch. 363, § 1; Laws, 2005, ch. 479, § 1; Laws, 2007, ch. 501, § 5; Laws, 2012, ch. 394, § 2; Laws, 2016, ch. 446, § 2, eff from and after July 1, 2016; reenacted and amended, Laws, 2018, ch. 362, § 2, eff from and after July 1, 2018.

Editor's Notes — Laws of 2016, ch. 446, § 4, was amended by Laws of 2018, ch. 362, § 4, to delete the July 1, 2018, repealer for this section.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Fee on every bond taken by bondsmen licensed under this chapter, see § 83-39-31.

Transfer of qualification bond, see, § 83-39-8.

JUDICIAL DECISIONS

1. In general.

Where a bail bondsman failed to take any action either prior to, on the day of, or within the 12-month period after the entry of final judgment to obtain relief and have a bond remitted to him, an application which was filed approximately 17 months after entry of final judgment was barred. State v. Ellis, 770 So. 2d 1041, 2000 Miss. App. LEXIS 513 (Miss. Ct. App. 2000).

Section 83-39-7, which provides that a bondsman may petition a court either for a refund of the money forfeited on final judgment or for a stay and remission of forfeiture, does not contemplate a stay and remission of forfeiture where the defendant is returned within 12 months but the judgment remains unpaid. Sides v. State, 519 So. 2d 1222, 1988 Miss. LEXIS 127 (Miss. 1988).

In an action by a bail bond corporation to set aside a final judgment of forfeiture of bail bonds written by the corporation, the trial court properly denied a refund where the final judgment of forfeiture had been entered before the corporation applied for and received several extensions of time to produce the defendant; such extensions of time were invalid since they may be obtained under this section only for the purpose of "delaying a final judgment of forfeiture." Allied Fidelity Ins. Co. v. State, 384 So. 2d 860, 1980 Miss. LEXIS 2012 (Miss. 1980).

Pursuant to § 83-39-7, a bail bondsman who can establish that a defendant is in lawful custody in another jurisdiction is entitled to an extension of time delaying final judgment on an appearance bond. Wood v. State, 345 So. 2d 616, 1977 Miss. LEXIS 2470 (Miss. 1977).

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Remission of bail bond should go to the licensed professional bondsmen, not to a third party who paid the judgment on his behalf; however, in the event of a known dispute, the court can order the remission interpled into chancery court with claimants as defendants for a determination of rights. Boothe, May 13, 1992, A.G. Op. #92-0330.

Where bond issued by professional bondsman has been forfeited, form which simply states supporting facts and orders Insurance Commissioner to revoke license of offending bondsman is sufficient to satisfy requirements of section. McCarty, July 15, 1992, A.G. Op. #92-0510.

Plain language of statute requires new total bond of $10,000.00 where bondsman making application for renewal has furnished bail in fifty or more cases. Weeks, March 2, 1994, A.G. Op. #94-0065.

If a defendant fails to appear for court as scheduled, the court should order the bond forfeited, issue a judgment nisi against the bondsman returnable for ninety days, and then the bonding company has ninety days to bring the defendant before the court; if the defendant is not produced within that period, then the judgment becomes final, the court may take actions to collect on the bond, and if the bondsman has not paid the bond within ninety days after the final judgment, then the court must order the Department of Insurance to revoke the license of the bondsman. Edwards, Aug. 19, 1997, A.G. Op. #97-0495.

RESEARCH REFERENCES

ALR.

State statutes making default on bail a separate criminal offense. 63 A.L.R.4th 1064.

Am. Jur.

43 Am. Jur. 2d, Insurance § 75.

3A Am. Jur. Legal Forms 2d, Bail and Recognizance §§ 35:2 et seq. (sureties).

CJS.

44 C.J.S., Insurance § 138.

§ 83-39-8. Managing and closing business upon death of personal surety.

If a professional bail agent who acts as a personal surety agent dies, the personal representative of the estate may contract with licensed professional bail agents, soliciting bail agents or bail enforcement agents to assist him in managing and closing the business affairs of the professional bail agent. The licensed professional bail agent, soliciting bail agent or bail enforcement agent contracted by the personal representative may, on behalf of the personal representative, present defendants in court when required, assist in the apprehension and surrender of defendants to the court, or keep defendants under necessary surveillance. Nothing herein shall give the personal representative the authority to execute and sign bail bonds in connection with judicial proceedings.

HISTORY: Laws, 2007, ch. 501, § 1; Laws, 2012, ch. 394, § 3, eff from and after July 1, 2012.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Fee on every bond taken by bondsmen licensed under this chapter, see § 83-39-31.

§ 83-39-9. Issuance of license.

The department upon receipt of the license application, the required fee, and proof of good moral character and, in the case of a professional bail agent, an approved qualification bond in the required amount, shall issue to the applicant a license to do business as a professional bail agent, soliciting bail agent or bail enforcement agent as the case may be.

No licensed professional bail agent shall have in his employ in the bail bond business any person who could not qualify for a license under this chapter, nor shall any licensed professional bail agent have as a partner or associate in such business any person who could not so qualify.

HISTORY: Codes, 1942, § 8745-03; Laws, 1968, ch. 341, § 3; Laws, 1994, ch. 495, § 5, eff from and after July 1, 1994.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

JUDICIAL DECISIONS

1. Suspension of license.

Appellate court affirmed a trial court judgment that affirmed the suspension of bail bond agent for six months from the bail bonding business pursuant to Miss. Code Ann. § 83-39-15 because the agent employed her husband, a convicted felon, in her business in violation of Miss. Code Ann. § 83-39-9. Davis-Everett v. Dale, 926 So. 2d 279, 2006 Miss. App. LEXIS 267 (Miss. Ct. App. 2006).

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Any person, regardless of the position to be held, that could not qualify for a license may not be employed by a licensed professional bail agent. Harrell, May 27, 2005, A.G. Op. 05-0196.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 75.

CJS.

44 C.J.S., Insurance § 138.

§ 83-39-11. License fees.

Each license application and application for license renewal to engage in the business of professional bail agent shall be accompanied by a fee of One Hundred Dollars ($100.00). Each license application and application for license renewal to engage in the business of soliciting bail agent or bail enforcement agent shall be accompanied by a fee of Forty Dollars ($40.00).

HISTORY: Codes, 1942, § 8745-04; Laws, 1968, ch. 341, § 4; Laws, 1994, ch. 495, § 6; Laws, 2007, ch. 501, § 6, eff from and after June 1, 2007.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Fee on every bond taken by bondsmen licensed under this chapter, see § 83-39-31.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance § 75.	44 C.J.S., Insurance § 138.

§ 83-39-13. Annual financial statement; maintenance and registration of office physically located in Mississippi municipality or county required; Bail Bond Database.

(1) Each professional bail agent licensed under this chapter, under oath, shall provide to the Insurance Department an annual financial statement. The annual financial statement shall show assets, liabilities and net worth as of the end of the most recent calendar year. The statement shall be submitted annually to the department by June 1.

(2)(a) For purposes of applicable examinations, a professional bail agent licensed in this state shall maintain at least one (1) office physically located in any municipality or county in this state, to serve as his principal place of business operations where records pertaining to his bail agent business conducted in Mississippi are maintained and this office location shall be registered with the Insurance Department.

(b) When applying for an original or renewal license as a professional bail agent, the applicant shall indicate the address of the office location to serve as his principal place of business operations, and this address shall be evidenced on the face of the license issued to the licensee.

(c) If for any reason the professional bail agent changes the location of his principal place of business operations, removes to another state, or no longer continues in the profession as a bail agent, the bail agent shall register the new location with the department, or notify the department of his removal from the state or his cessation of business as a professional bail agent as appropriate.

(3) On or before October 1, 2016, the Mississippi Insurance Department shall establish a Bail Bond Database within the department for the reporting of all bail bonds written by personal surety agents and limited surety agents in this state. By November 15, 2016, each bail agent must input his or her bail bond information into the Bail Bond Database for all bonds written from and after October 1, 2016. By the fifteenth day of each subsequent month, each bail agent must update the Bail Bond Database regarding his or her bail bond information for bail bonds written from and after October 1, 2016, and each update must be current through the last day of the previous month. Any bail agent who fails to comply with the provisions of this subsection (3) shall be

assessed a fine in an amount not to exceed One Thousand Dollars ($1,000.00) per violation.

HISTORY: Codes, 1942, § 8745-05; Laws, 1968, ch. 341, § 5; Laws, 1984, ch. 436; Laws, 1994, ch. 495, § 7; Laws, 1998, ch. 323, § 7; Laws, 2011, ch. 463, § 5; Laws, 2016, ch. 446, § 3, eff from and after July 1, 2016; reenacted without change, Laws, 2018, ch. 362, § 3, eff from and after July 1, 2018.

Editor's Notes — Laws of 2016, ch. 446, § 4, was amended by Laws of 2018, ch. 362, § 4, to delete the July 1, 2018, repealer for this section.

§ 83-39-15. Grounds for denial, suspension, revocation, and refusal to renew license.

(1) The department may deny, suspend, revoke or refuse to renew, as may be appropriate, a license to engage in the business of professional bail agent, soliciting bail agent, or bail enforcement agent for any of the following reasons:

(a) Any cause for which the issuance of the license would have been refused had it then existed and been known to the department.

(b) Failure to post a qualification bond in the required amount with the department during the period the person is engaged in the business within this state or, if the bond has been posted, the forfeiture or cancellation of the bond.

(c) Material misstatement, misrepresentation or fraud in obtaining the license.

(d) Willful failure to comply with, or willful violation of, any provision of this chapter or of any proper order, rule or regulation of the department or any court of this state.

(e) Conviction of felony or crime involving moral turpitude.

(f) Default in payment to the court should any bond issued by such bail agent be forfeited by order of the court.

(g) Being elected or employed as a law enforcement or judicial official.

(h) Engaging in the practice of law.

(i) Writing a bond in violation of Section 83-39-3(2) (b) (i) and (ii).

(j) Giving legal advice or a legal opinion in any form.

(k) Acting as or impersonating a bail agent without a license.

(*l*) Use of any other trade name than what is submitted on a license application to the department.

(m) Issuing a bail bond that contains information intended to mislead a court about the proper delivery by personal service or certified mail of a writ of scire facias, judgment nisi or final judgment.

(2) In addition to the grounds specified in subsection (1) of this section, the department shall be authorized to suspend the license, registration or permit of any person for being out of compliance with an order for support, as defined in Section 93-11-153. The procedure for suspension of a license, registration or permit for being out of compliance with an order for support, and the procedure for the reissuance or reinstatement of a license, registration or permit suspended for that purpose, and the payment of any fees for the reissuance or

reinstatement of a license, registration or permit suspended for that purpose, shall be governed by Section 93-11-157 or 93-11-163, as the case may be. If there is any conflict between any provision of Section 93-11-157 or 93-11-163 and any provision of this chapter, the provisions of Section 93-11-157 or 93-11-163, as the case may be, shall control.

(3) In addition to the sanctions provided in this section, the department may assess an administrative fine in an amount not to exceed One Thousand Dollars ($1,000.00) per violation. Such administrative fines shall be in addition to any criminal penalties assessed under Section 99-5-1.

HISTORY: Codes, 1942, § 8745-06; Laws, 1968, ch. 341, § 6; Laws, 1994, ch. 495, § 8; Laws, 1996, ch. 507, § 89; Laws, 2001, ch. 563, § 2; Laws, 2010, ch. 466, § 3; Laws, 2014, ch. 479, § 2, eff from and after July 1, 2014.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

JUDICIAL DECISIONS

ANALYSIS

1. Suspension of license.
2. State/local regulation.

1. Suspension of license.

Appellate court affirmed a trial court judgment that affirmed the suspension of bail bond agent for six months from the bail bonding business pursuant to Miss. Code Ann. § 83-39-15 because the agent employed her husband, a convicted felon, in her business in violation of Miss. Code Ann. § 83-39-9. Davis-Everett v. Dale, 926 So. 2d 279, 2006 Miss. App. LEXIS 267 (Miss. Ct. App. 2006).

2. State/local regulation.

Where a state judge had held that county sheriffs had no discretion under Miss. Code Ann. § 89-39-15 to suspend bond-writing rights, the district court's summary judgment to defendant county on a due process claim was reversed; defendant sheriff's decision to remove plaintiff bonding agents from the approved list could be the basis of the county's due process liability based on policy and custom. Hampton Co. Nat'l Sur. LLC v. Tunica County Miss., 543 F.3d 221, 2008 U.S. App. LEXIS 20068 (5th Cir. Miss. 2008).

OPINIONS OF THE ATTORNEY GENERAL

A convicted felon cannot be issued a professional bail agent's license, although the Department of Insurance has discretion to take action against an individual who has already been licensed and then is convicted of a felony. Dale, Nov. 5, 1999, A.G. Op. #99-0579.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 77.

CJS.

44 C.J.S., Insurance § 138.

§ 83-39-17. Hearing.

Before any license shall be refused or suspended or revoked, or the renewal thereof refused hereunder, the commissioner shall give notice of his intention to do so, by registered mail, to the applicant or licensee and to the insurer or professional bail agent appointing or employing the applicant or licensee, as the case may be, and shall set a date, not less than twenty (20) days from the date of mailing the notice, when the applicant or licensee and a duly authorized representative of the insurer or professional bail agent may appear to be heard and produce evidence. In the conduct of the hearing, the commissioner or any regular salaried employee specially designated by him for this purpose shall have power to administer oaths, to require the appearance of and examine any person under oath, and to require the production of books, records, or papers relevant to the inquiry upon his own initiative or upon the request of the applicant or licensee. Upon the termination of the hearing, findings shall be reduced to writing and, upon approval by the commissioner, shall be filed in his office and notice of the findings sent by registered mail to the applicant or licensee and the insurer or professional bail agent concerned.

HISTORY: Codes, 1942, § 8745-06; Laws, 1968, ch. 341, § 6; Laws, 1994, ch. 495, § 9; Laws, 2001, ch. 461, § 2, eff from and after July 1, 2001.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Exemption from requirements of this section for denial of application for renewal license, see § 83-39-3(8)(b).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 77.

CJS.
44 C.J.S., Insurance § 138.

§ 83-39-19. Appeals.

Any person aggrieved by an act of the commissioner under the provisions of this chapter may appeal therefrom, within thirty (30) days after receipt of notice thereof, to the circuit court of the county in which is located the domicile of said person by writ of certiorari, upon giving bond with the surety or sureties and in such penalty as shall be approved by the circuit clerk of said county, conditioned that such appellant will pay all costs of the appeal in the event such appeal is not prosecuted successfully. The said circuit court shall have the opportunity and jurisdiction to hear said appeal and render its decision in regard thereto, either in termtime or vacation time.

Actions taken by the commissioner or department in suspending a license, registration or permit when required by Section 93-11-157 or 93-11-163 are not actions from which an appeal may be taken under this section. Any appeal of a suspension of a license, registration or permit that is required by Section 93-11-157 or 93-11-163 shall be taken in accordance with the appeal procedure specified in Section 93-11-157 or 93-11-163, as the case may be, rather than the procedure specified in this section.

HISTORY: Codes, 1942, § 8745-06; Laws, 1968, ch. 341, § 6; Laws, 1996, ch. 507, § 90, eff from and after July 1, 1996.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 68.

§ 83-39-21. Judicial proceeding in lieu of departmental hearing.

The commissioner, in his discretion, in lieu of the hearing provided for in Section 83-39-17, may file a petition to suspend or revoke any license authorized hereunder in a court of competent jurisdiction of the county or district in which the alleged offense occurred. In such cases, subpoenas may be issued for witnesses, and mileage and witness fees paid by the defendant, if found guilty. If costs cannot be made and collected from the defendant, the costs shall be assessed against the qualification bond if the defendant is a professional bail agent, and if the defendant is a soliciting bail agent or bail enforcement agent, against the employing professional bail agent or his qualification bond.

Any court of competent jurisdiction within this state may suspend or revoke the license of any person licensed under this chapter for any of the following reasons:

(a) Misappropriation, conversion or unlawful withholding of monies belonging to insured principals or others and received in the conduct of business under a license provided by this chapter.

(b) Fraudulent or dishonest practices in the conduct of the business under a license provided by this chapter.

(c) The commission of any act which would prohibit or restrict the licensee from holding a license under this chapter.

The court which suspends or revokes a license under the terms of this chapter, or the clerk thereof, shall promptly furnish the commissioner a copy of the suspension or revocation order.

HISTORY: Codes, 1942, § 8745-06; Laws, 1968, ch. 341, § 6; Laws, 1994, ch. 495, § 10, eff from and after July 1, 1994.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 67.

§ 83-39-23. Notice to sheriff and judicial officials.

No sheriff or other official shall accept bond from a professional bail agent unless the bail agent is licensed under this chapter and unless the bail agent shall exhibit to the court a valid certificate or license issued by the department, and the license of the bail agent shall not have been suspended or revoked. The department shall provide notice to the sheriff and municipal law enforcement and to the courts of every county and municipality of any suspension or revocation of a professional, soliciting or bail enforcement license. The department, upon request, may furnish to any sheriff, district, circuit, county or justice court judge or municipal judge additional information which would appropriately identify the duly licensed professional bail agent and insurers whose operation is covered by this chapter.

HISTORY: Codes, 1942, § 8745-07; Laws, 1968, ch. 341, § 7; Laws, 1994, ch. 495, § 11; Laws, 2014, ch. 479, § 3, eff from and after July 1, 2014.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

JUDICIAL DECISIONS

1. In general.

Company whose name was forged on bail bonds by an unauthorized person will not be subjected to forfeiture judgments on bonds, and the company is not estopped to assert the truth in view of the fact that it had no knowledge of the forgery or that certain powers of attorney issued to a deceased agent came into the possession of a person not its agent, particularly where the deputy sheriff who accepted the bonds made no investigation as to the authority of the person executing and tendering them. Resolute Ins. Co. v. State, 290 So. 2d 599, 1974 Miss. LEXIS 1704 (Miss. 1974).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 75.

CJS.

44 C.J.S., Insurance § 138.

§ 83-39-25. Maximum premium, commission or fee; processing fee; holding collateral to insure payment of premium or indemnify for losses.

(1) A professional bail agent or his agent shall charge and collect for his premium, commission, or fee an amount of ten percent (10%) of the amount of bail per bond posted by him, or One Hundred Dollars ($100.00), whichever is greater, except on a bond on a defendant who is charged with a capital offense, or on a defendant who resides outside the State of Mississippi, in which case the premium, commission or fee shall be fifteen percent (15%) of the amount of bail, per bond posted by him, or One Hundred Dollars ($100.00), whichever is greater.

(2) A professional bail agent or his agent shall also charge an additional Fifty Dollars ($50.00) processing fee on each bond issued by him.

(3) Nothing herein shall prohibit a professional bail agent or his agent from holding collateral or taking a security interest in collateral for the purpose of insuring the payment of the premium of the bond posted or

indemnifying the professional bail agent for losses incurred due to a forfeiture of a bond or the costs of apprehension and surrender of the principal.

(4) Any fee charged by a professional bail agent or his agent for court-approved electronic monitoring or drug testing shall not be considered part of the premium, commission or fee charged under this section.

HISTORY: Codes, 1942, § 8745-08; Laws, 1968, ch. 341, § 8; Laws, 1994, ch. 495, § 12; Laws, 1994, ch. 634, § 1; Laws, 2001, ch. 350, § 1; Laws, 2007, ch. 501, § 2; Laws, 2009, ch. 520, § 1; Laws, 2011, ch. 463, § 6, eff from and after July 1, 2011.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Limits on fee as specified in this section not to include fee imposed on each bond taken by bondsmen, see § 83-39-31.

OPINIONS OF THE ATTORNEY GENERAL

The only charges a professional bail agent or his agent may charge are set forth in Section 83-39-25. Champion, Sept. 23, 2005, A.G. Op. 05-0387.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 76.

CJS.
44 C.J.S., Insurance § 138.

§ 83-39-27. Prohibited activities.

It is unlawful for a licensee to engage in any of the following activities:

(a) Specify, suggest or advise the employment of any particular attorney to represent his principal.

(b) Pay a fee or rebate or give or promise to give anything of value to a jailer, policeman, peace officer, clerk, deputy clerk, any other employee of any court, district attorney or any of his employees or any person who has power to arrest or to hold any person in custody.

(c) Pay a fee or rebate or give anything of value to an attorney in bail bond matters, except in defense of any act on a bond, or as counsel to represent such bail agent, his agent or employees.

(d) Pay a fee or rebate or give or promise to give anything of value to the person on whose bond he is surety.

(e) Pay a fee or rebate or give or promise to give anything of value to any person, other than a soliciting bail agent, for the purpose of procuring a bail bond.

(f) Accept anything of value from a person on whose bond he is surety, or from others on behalf of such person, except the fee or premium on the bond, but the bail agent may accept collateral security or other indemnity.

(g) Coerce, suggest, aid and abet, offer promise of favor or threaten any person on whose bond he is surety or offers to become surety, to induce that person to commit any crime.

(h) Give legal advice or a legal opinion in any form.

(i) Refuse to return collateral security or other indemnity when the fee or premium on the bond has been fully paid or when the bail agent's obligation on the bond has been terminated.

HISTORY: Codes, 1942, § 8745-09; Laws, 1968, ch. 341, § 9; Laws, 1994, ch. 495, § 13; Laws, 2001, ch. 320, § 1; brought forward without change, Laws, 2010, ch. 466, § 5; Laws, 2011, ch. 463, § 7; Laws, 2012, ch. 394, § 4, eff from and after July 1, 2012.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

JUDICIAL DECISIONS

1. Exceeded scope of authority.

Defendants exceeded the scope of their authority as bail bondsmen and had no lawful authority to kidnap the victim for nonpayment of the bond because, once the victim informed them that he could not provide any payment, defendants ordered him to obtain illegal drugs, after he was unsuccessful they handcuffed him and put him in the trunk of the vehicle and held him against his will, rather than taking him back to jail. Magee v. State, — So. 3d —, 2022 Miss. App. LEXIS 108 (Miss. Ct. App. Apr. 5, 2022).

OPINIONS OF THE ATTORNEY GENERAL

Where justice court bond is $10,000 and defendant has to pay ten percent or $1,000 dollars to bondsman to get bonded out, bondsman's taking of $500 down and $100 per week is legal, since nothing in Miss. Code Section 83-39-27 prohibits this activity. Ferguson, June 9, 1993, A.G. Op. #93-0331.

Subsection (d) is not violated by a bondsman taking credit from a defendant in order to post bail. Foretich, August 10, 1998, A.G. Op. #98-0455.

§ 83-39-29. Penalties.

(1) The department may provide information to the district attorney in the district in which a professional bail agent, a soliciting bail agent or bail enforcement agent is domiciled so that proper legal action may be pursued against any licensee who is alleged to have violated any provision of Chapter 39, Title 83. Such licensee is guilty of a misdemeanor and shall be subject to a fine of not more than One Thousand Dollars ($1,000.00), imprisonment in the county jail for not more than one (1) year, or both. Any insurer violating any provision of Chapter 39, Title 83 may be fined in an amount not to exceed Fifty Thousand Dollars ($50,000.00).

(2) Any person or entity who acts or attempts to solicit, write or present a bail bond as a professional bail agent, soliciting bail agent, or bail enforcement agent as defined in this chapter and who is not licensed under this chapter is guilty of a misdemeanor and, upon conviction, shall be subject to a fine of not more than One Thousand Dollars ($1,000.00), imprisonment in the county jail for not more than one (1) year, or both.

(3) Any person who acts or attempts to act, represents himself to be, or impersonates a professional bail agent, a soliciting bail agent or a bail enforcement agent as defined in this chapter by attempting to arrest or detaining any person, and who is not licensed under this chapter, is guilty of a

misdemeanor and, upon conviction, shall be subject to a fine of not more than Five Thousand Dollars ($5,000.00), imprisonment for not more than one (1) year, or both.

(4) A bail agent, bail enforcement agent or bail enforcement agent from another state shall report to the sheriff's department of the county in which he is attempting to locate a fugitive prior to beginning to look for the fugitive to prove his licensing and legal right to the fugitive. Failure to prove licensing shall be an offense punishable by a fine not to exceed One Thousand Dollars ($1,000.00).

(5) Any person charged with a criminal violation who has obtained his release from custody by having a professional bail agent, insurer, agent of a bail agent or insurer, or any person other than himself furnish his bail bond and who fails to appear in court, at the time and place ordered by the court, is guilty of "bond jumping" and, upon conviction, shall be subject to a fine of not more than One Thousand Dollars ($1,000.00), imprisonment in the county jail for not more than one (1) year, or both, and payment of restitution for reasonable expenses incurred returning the defendant to court.

(6) Any person who knowingly and intentionally aids and abets any person in the commission of the offense of bond jumping, whether the person committing the principal offense is actually convicted, shall be guilty of aiding and abetting bond jumping and, upon conviction, shall be subject to a fine of not more than One Thousand Dollars ($1,000.00) or imprisonment in the county jail for not more than one (1) year, or both, and payment of restitution for reasonable expenses incurred in returning the defendant to court. Any person who is convicted of aiding and abetting shall be jointly and severally liable for payment of restitution for reasonable expenses incurred in returning the defendant to court.

(7) Any bail agent who is prejudiced or injured by the commission of any of the offenses set forth in this section shall have standing to file a complaint alleging the commission of the offense or offenses.

HISTORY: Codes, 1942, §§ 8745-09, 8745-10; Laws, 1968, ch. 341, §§ 9, 10; Laws, 1994, ch. 495, § 14; Laws, 1994, ch. 634, § 2; Laws, 2003, ch. 466, § 1; Laws, 2005, ch. 412, § 1; Laws, 2009, ch. 520, § 2; brought forward without change, Laws, 2010, ch. 466, § 6; Laws, 2014, ch. 479, § 5, eff from and after July 1, 2014.

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

OPINIONS OF THE ATTORNEY GENERAL

A defendant who has been released on his own recognizance and fails to appear in court for his hearing does not meet the requisite elements to be charged with bondjumping. Busby, July 23, 2004, A.G. Op. 04-0316.

RESEARCH REFERENCES

ALR.

State statutes making default on bail a separate criminal offense. 63 A.L.R.4th 1064.

Am. Jur.

43 Am. Jur. 2d, Insurance § 69.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

CJS.

44 C.J.S., Insurance § 139.

§ 83-39-30. Prohibited activities; illegal business referrals.

(1) Any person licensed under this chapter who pays or gives anything of value, either directly or indirectly, to any law enforcement or judicial official or any employee of any facility where defendants who are or may be eligible for bail are detained or may post bail for the purpose of enticing that official or employee to refer business in any manner to them shall be guilty of a felony subject to imprisonment for not more than five (5) years or a fine of not more than Fifty Thousand Dollars ($50,000.00), or both. Nothing in this section shall prohibit a bail agent from making political contributions to persons running for public office.

(2) Any person licensed under this chapter who pays or gives anything of value, either directly or indirectly, or who solicits another person to pay or give anything of value to any convicted inmate or trustee, regardless of whether they are held pretrial or post-conviction in any facility where defendants who are or may be eligible for bail are detained or may post bail for the purpose of enticing that convicted inmate or trustee to refer business in any manner to them shall be guilty of a felony subject to imprisonment for not more than five (5) years or a fine of not more than Fifty Thousand Dollars ($50,000.00), or both.

(3) Any person who is convicted under this section shall have their license permanently revoked and may not be involved in any bail business in any way.

HISTORY: Laws, 2014, ch. 479, § 6, eff from and after July 1, 2014.

§ 83-39-31. Fee on appearance bonds and recognizances; additional assessment on bail bonds to be deposited into Victims of Domestic Violence Fund.

(1) Upon every defendant charged with a criminal offense who posts a cash bail bond, a surety bail bond, a property bail bond or a guaranteed arrest bond certificate conditioned for his appearance at trial, there is imposed a fee equal to two percent (2%) of the face value of each bond or Twenty Dollars ($20.00), whichever is greater, to be collected by the clerk of the court when the defendant appears in court for final adjudication or at the time the defendant posts cash bond unless subsection (4) applies.

(2) Upon each defendant charged with a criminal offense who is released on his own recognizance, who deposits his driver's license in lieu of bail, or who

is released after arrest on written promise to appear, there is imposed a fee of Twenty Dollars ($20.00) to be collected by the clerk of the court when the defendant appears in court for final adjudication unless subsection (4) applies.

(3) Upon each defendant convicted of a criminal offense who appeals his conviction and posts a bond conditioned for his appearance, there is imposed a fee equal to two percent (2%) of the face value of each bond or Twenty Dollars ($20.00), whichever is greater. If such defendant is released on his own recognizance pending his appeal, there is imposed a fee of Twenty Dollars ($20.00). The fee imposed by this subsection shall be imposed and shall be collected by the clerk of the court when the defendant posts a bond unless subsection (4) applies.

(4) If a defendant is found to be not guilty or if the charges against a defendant are dismissed, or if the prosecutor enters a nolle prosequi in the defendant's case or retires the defendant's case to the file, or if the defendant's conviction is reversed on appeal, the fees imposed pursuant to subsections (1), (2), (3) and (7) shall not be imposed.

(5) The State Auditor shall establish by regulation procedures providing for the timely collection, deposit, accounting and, where applicable, refund of the fees imposed by this section. The Auditor shall provide in the regulations for certification of eligibility for refunds and may require the defendant seeking a refund to submit a verified copy of a court order or abstract by which the defendant is entitled to a refund.

(6) It shall be the duty of the clerk or any officer of the court authorized to take bonds or recognizances to promptly collect, at the time such bonds or recognizances are received or taken, all fees imposed pursuant to this section. In all cases, the clerk or officer of the court shall deposit all fees so collected with the State Treasurer, pursuant to appropriate procedures established by the State Auditor, for deposit into the State General Fund.

(7) In addition to the fees imposed by this section, there shall be an assessment of Ten Dollars ($10.00) imposed upon every criminal defendant charged with a criminal offense who posts a cash bail bond, a surety bail bond, a property bail bond or a guaranteed arrest bond to be collected by the clerk of the court and deposited in the Victims of Domestic Violence Fund created by Section 93-21-117, unless subsection (4) applies.

HISTORY: Laws, 1990, ch. 329, § 2; Laws, 1994, ch. 495, § 15; Laws, 1995, ch. 371, § 1; Laws, 1999, ch. 364, § 1; Laws, 2009, ch. 463, § 1; Laws, 2011, ch. 339, § 1, eff from and after passage (approved Mar. 14, 2011).

Editor's Notes — Section 7-7-2, as added by Laws, 1984, chapter 488, § 90, and amended by Laws, 1985, chapter 455, § 14, Laws, 1986, chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor," and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws, 1989, chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws, 1989, ch. 544, § 17, effective July 1, 1989, and codified as § 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration."

Cross References — Exemption from requirement for license for carrying concealed pistol or revolver of persons licensed under this chapter, see § 45-9-101.

OPINIONS OF THE ATTORNEY GENERAL

Where defendant is not adjudicated guilty or there is successful pretrial diversion, fees imposed may be returned to defendant pursuant to Section 83-39-31(5). Brown, July 8, 1993, A.G. Op. #93-0283.

Bond fee demanded by 83-39-31(4) is applicable to appearance bond posted by criminal defendant appealing conviction from circuit court to state supreme court. Dyson, August 5, 1993, A.G. Op. #93-0439.

Under this section, the clerk must keep a list of the bonds posted and the cases wherein the State has failed to obtain a conviction, in which cases the fees paid are subject to refund. However, it does not require a justice court clerk to prepare a weekly list of names for the benefit of a private citizen or a business i.e. bail bondsman. Corviss, February 16, 1995, A.G. Op. #95-0074.

A defendant released by a justice court judge on a recognizance bond does not have to pay a bond fee until he/she appears in court for final adjudication. Bush, Dec. 5, 1997, A.G. Op. #97-0761.

There is no authority to charge a $25.00 bail bond fee on DUI's and misdemeanors; the statute provides for a fee equal to two percent of the face value of a bond or $20.00, whichever is greater, for every defendant charged with a criminal offense who posts a bond; this fee should be imposed for DUI's and misdemeanors, but is not to be collected if the defendant is found not guilty or the charges are dismissed. Barnett, May 19, 2000, A.G. Op. #2000-0272.

Based on subsection (4), no bond fee should be imposed if the charges against the defendant are dismissed or remanded. Green, June 30, 2000, A.G. Op. #2000-0337.

Either two percent of the face value of each cash bond or $20.00, whichever is greater, must be collected at the time a defendant posts a cash bond by the officer who takes the bond, and the clerk of the court must collect the bond fee that may be due for any other type of bond, i.e., surety bond, property bond, etc. Thomas, Mar. 29, 2002, A.G. Op. #02-0148.

The 2%/$20 fee shall not be imposed and therefore not collected from individuals ordered into the Eighth Judicial District Drug Court. Henderson, Sept. 30, 2005, A.G. Op. 05-0430.

Payments of the fine to the clerk constitutes an appearance and final adjudication for purposes of collecting the required $ 20.00 fee. Lexington Municipal Judge, Sept. 5, 2006, A.G. Op. 06-0412.

CHAPTER 41.

HOSPITAL AND MEDICAL SERVICE ASSOCIATIONS AND CONTRACTS

Article 1.	Hospital Service Associations. [Repealed].	83-41-1
Article 3.	Nonprofit Hospital, Medical, and Surgical Service Corporations. [Repealed].	83-41-101
Article 5.	Provisions Common to Hospital, Medical, or Surgical Insurance.	83-41-201
Article 7.	Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plans Protection Act.	83-41-301
Article 9.	Patient Protection Act of 1995.	83-41-401

ARTICLE 1.

HOSPITAL SERVICE ASSOCIATIONS [REPEALED].

Sec.
83-41-1 through 83-41-19. Repealed.

§§ 83-41-1 through 83-41-19. Repealed.

Repealed by Laws, 1997, ch. 307, § 1, eff from and after July 1, 1997.

§§ 83-41-1 through 83-41-19. [Codes, 1942, §§ 5606-5615; Laws, 1936, ch. 177]

Editor's Notes — Former §§ 83-41-1 through 83-41-19 provided for the organization and regulation of hospital and medical service associations by the Commissioner of Insurance.

ARTICLE 3.

NONPROFIT HOSPITAL, MEDICAL, AND SURGICAL SERVICE CORPORATIONS [REPEALED]

Sec.
83-41-101 through 83-41-131. Repealed.

§§ 83-41-101 through 83-41-131. Repealed.

Repealed by Laws, 1997, ch. 307, § 2, eff from and after July 1, 1997.

§§ 83-41-101 through 83-41-123. [Codes, 1942, §§ 5615-01-5615-12; Laws, 1948, ch. 349, §§ 1-12]

§ 83-41-125. [Codes, 1942, § 5615-13; Laws, 1948, ch. 349, § 13; Laws, 1994, ch. 422, § 4]

§ 83-41-127. [Codes, 1942, § 5615-14; Laws, 1948, ch. 349, § 14; Laws, 1956, ch. 341; Laws, 1978, ch. 441, § 8]

§ 83-41-129. [Codes, 1942, § 5615-15; Laws, 1948, ch. 349, § 15]

§ 83-41-131. [Codes, 1942, § 5615-16; Laws, 1948, ch. 349, § 16; Laws, 1994, ch. 422, § 5]

Editor's Notes — Former §§ 83-41-101 through 83-41-123 provided for the organization and regulation of nonprofit hospital, medical and surgical service corporations by the Commissioner of Insurance.

Former § 83-41-125 directed that any dissolution, liquidation supervision or rehabilitation of a corporation be conducted by the Commissioner of Insurance.

Former § 83-41-127 provided that charitable and benevolent corporations be exempt from taxation.

Former § 83-41-129 provided for the conversion of existing service corporations into nonprofit corporations.

Former § 83-41-131 provided for the conversion of nonprofit hospital, medical and surgical corporations to mutual insurance companies.

ARTICLE 5.

PROVISIONS COMMON TO HOSPITAL, MEDICAL, OR SURGICAL INSURANCE.

Sec.	
83-41-201.	Notice to insured required for cancellation.
83-41-203.	Beneficiaries' freedom of choice of practitioner in performance of visual service; optometrists.
83-41-205.	Individual hospital and medical expense contracts and policies shall provide for continuation of coverage for persons having an intellectual or physical disability.
83-41-207.	Group hospital and medical expense contracts and policies shall provide for continuation of coverage for persons having an intellectual or physical disability.
83-41-209.	Beneficiaries' freedom of choice of practitioner in performance of dental services.
83-41-211.	Beneficiaries' freedom of choice of practitioner in treatment of mental, nervous or emotional disorders; psychologist, professional counselor or clinical social worker.
83-41-213.	Right of insureds or other beneficiaries to be reimbursed for services performed by physicians or nurse practitioners within lawful scope of their practice.
83-41-214.	Payment by third parties of certified nurse practitioners.
83-41-215.	Right of beneficiary or insured to reimbursement for services performed by chiropractor; freedom of choice of practitioner and place of services.
83-41-217.	Direct access to obstetricians/gynecologists to be allowed; status as primary care physicians.
83-41-219.	Reciprocal time limitations on health insurance claim filing and claim audits; applicability [See Editor's Notes for effective date and applicability].

§ 83-41-201. Notice to insured required for cancellation.

Whenever any policy of hospital, medical, or surgical insurance issued or renewed after June 11, 1964, shall have been in continuous full force and effect for at least four (4) years with all premiums paid thereon, no insurance company chartered or authorized to do business in the State of Mississippi, or doing business herein, shall be permitted to cancel or refuse to renew its policy of hospital, medical, or surgical insurance issued after said date to a resident citizen of the State of Mississippi without first giving written notice to the insured; and the cancellation or refusal to renew shall not be effective until one (1) year from and after the date of the receipt of such written notice as shown by certified mail sent with return receipt requested. Any effort to cancel a policy of hospital, medical, or surgical insurance or any refusal to accept premiums on such a policy contrary to the provisions of this section shall be ineffective if the policyholder makes an offer to pay the premium as and when due, or within the grace period, and one (1) offer shall be all that is necessary if that offer is refused by the company.

The provisions of this section shall not apply to group and blanket insurance, nor to any policy in which the insurer does not reserve the right to refuse renewal on an individual basis. The provisions of this section shall not prevent cancellation of any hospital, medical, or surgical insurance policy because of duplicate coverage providing for payment of benefits in excess of hospital, medical, nursing, or drug expenses actually incurred.

HISTORY: Codes, 1942, § 5615-31; Laws, 1964, ch. 473, § 1, eff from and after passage (approved June 11, 1964).

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in the first sentence of the last paragraph. The word "insuror" was changed to "insurer." The Joint Committee ratified the correction at its May 20, 1998, meeting.

Cross References — Required provisions of accident and sickness policy, see § 83-9-5.

JUDICIAL DECISIONS

1. In general.

Allegations of a bill of complaint charging improper premium rate increases in health and accident policies leading to the increased payments by some policyholders and to policy terminations by others, were not within the ambit of this section [Code 1942 § 5615-31] and did not properly charge a violation of it. Gandy v. Reserve Life Ins. Co., 279 So. 2d 648, 1973 Miss. LEXIS 1489 (Miss. 1973).

RESEARCH REFERENCES

ALR.

Elimination of particular coverage, or termination, of health, hospitalization, or medical care insurance policy as affecting insurer's liability for insured's continuing hospitalization or medical expenses relating to previously covered illness. 66 A.L.R.3d 1205.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 433 et seq.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance, Form No. 184 (answer containing defense of cancellation of policy by insurer prior to loss-notice of cancellation mailed and unearned premium refunded).

14 Am. Jur. Pl & Pr Forms (Rev), Insur-

ance, Form No. 185 (answer containing defense of cancellation policy by insurer prior to loss-policy surrendered to insurer after notice of cancellation and return of unearned premiums).

CJS.
45 C.J.S., Insurance §§ 674 et seq.

§ 83-41-203. Beneficiaries' freedom of choice of practitioner in performance of visual service; optometrists.

Whenever any policy of insurance or any medical service plan or hospital service contract or hospital and medical service contract issued in this state provides for reimbursement for any visual service which is within the lawful scope of practice of a duly licensed optometrist as defined in Section 73-19-1, Mississippi Code of 1972, the insured or other person entitled to benefits under such policy shall be entitled to reimbursement for such services, whether such services are performed by a duly licensed physician or by a duly licensed optometrist, notwithstanding any provision to the contrary in any statute or in such policy, plan or contract. Duly licensed optometrists shall be entitled to participate in such policies, plans, or contracts providing for visual services, as authorized by Sections 73-19-1 and 43-3-67, Mississippi Code of 1972, to the same extent as duly licensed physicians.

HISTORY: Codes, 1942, § 5615-41; Laws, 1966, ch. 527, § 1, eff from and after passage (approved February 23, 1966).

RESEARCH REFERENCES

Am. Jur.
44A Am. Jur. 2d, Insurance § 1591.

§ 83-41-205. Individual hospital and medical expense contracts and policies shall provide for continuation of coverage for persons having an intellectual or physical disability.

Any individual hospital or medical service plan contract or any individual hospital or medical expense insurance policy delivered or issued for delivery in this state after September 12, 1972, which provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the contract or policy, shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of having an intellectual disability or a physical disability, and (b) chiefly dependent upon the subscriber or policyholder for support and maintenance, provided proof of such incapacity and dependency is furnished to the hospital or medical service plan corporation or insurer by the subscriber or policyholder within thirty-one (31) days of the child's attainment of the limiting age and subsequently as may be required by the corporation or insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Any insurer or hospital service plan corporation continuing dependent coverage beyond the limiting age for dependent children as prescribed by this section, shall have the right to charge the standard adult premium for such coverage.

HISTORY: Codes, 1942, §§ 5615-51, 5615-53; Laws, 1972, ch. 499, §§ 1, 3; Laws, 2010, ch. 476, § 76, eff from and after passage (approved Apr. 1, 2010).

§ 83-41-207. Group hospital and medical expense contracts and policies shall provide for continuation of coverage for persons having an intellectual or physical disability.

Any group hospital or medical service plan contract or any group hospital or medical expense insurance policy delivered or issued for delivery in this state after September 12, 1972, which provides that coverage of a dependent child of an employee, insured party, or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the contract or policy, shall also provide in substance that attainment of such limiting age shall not operate to terminate the coverage of such child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of having an intellectual disability or a physical disability, and (b) chiefly dependent upon the employee, insured party, or member for support and maintenance, provided proof of such incapacity and dependency is furnished to the hospital or medical service plan corporation or insurer by the employee, insured party, or member within thirty-one (31) days of the child's attainment of the limiting age and subsequently as may be required by the corporation or insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Any insurer or hospital service plan corporation continuing dependent coverage beyond the limiting age for dependent children as prescribed by this section, shall have the right to charge the standard adult premium for such coverage.

HISTORY: Codes, 1942, §§ 5615-52, 5615-53; Laws, 1972, ch. 499, §§ 2, 3; Laws, 2010, ch. 476, § 77, eff from and after passage (approved Apr. 1, 2010).

§ 83-41-209. Beneficiaries' freedom of choice of practitioner in performance of dental services.

Whenever any policy of insurance or any medical service plan or hospital service contract or hospital and medical service contract issued in this state provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed dentist, as defined by the laws of the State of Mississippi, the insured, or other person entitled to benefits under such policy, shall be entitled to reimbursement for such services, whether such services are performed by a duly licensed physician or by a duly licensed dentist, notwithstanding any provision to the contrary in any statute or in such policy, plan or contract; duly licensed dentists shall be entitled to participate in such policies, plans or contracts providing for dental services, as authorized by the laws of the State of Mississippi.

HISTORY: Laws, 1974, ch. 406, eff from and after passage (approved March 25, 1974).

Cross References — Practice of dentistry or dental hygiene generally, see §§ 73-9-1 et seq.

Definition of the term "dentists," see § 73-9-3.

Nonprofit dental service corporations, see §§ 83-43-1 et seq.

§ 83-41-211. Beneficiaries' freedom of choice of practitioner in treatment of mental, nervous or emotional disorders; psychologist, professional counselor or clinical social worker.

Whenever any policy of insurance or any medical service plan or hospital service contract or hospital and medical service contract issued in this state provides for reimbursement for any diagnosis and treatment of mental, nervous or emotional disorders only which are within the lawful scope of practice of a duly licensed psychologist as defined in Section 73-31-3, within the lawful scope of practice of a duly licensed professional counselor as defined in Section 73-30-3, within the lawful scope of practice of a duly licensed clinical social worker as defined in Section 73-53-3, or within the lawful scope of practice of a duly licensed marriage and family therapist as defined in Section 73-54-5, the insured or other person entitled to benefits under such policy shall be entitled to reimbursement for such services, whether such services are performed by a duly licensed physician or by a duly licensed psychologist, by a duly licensed professional counselor, by a duly licensed clinical social worker or by a duly licensed marriage and family therapist, notwithstanding any provision to the contrary in any statute or in such policy, plan or contract. Duly licensed psychologists shall be entitled to participate in such policies, plans or contracts providing for the diagnosis and treatment of mental, nervous or emotional disorders only as authorized by Section 73-31-3. A duly licensed professional counselor shall be entitled to participate in such policies, plans or contracts providing for the diagnosis and treatment of mental, nervous or emotional disorders only as authorized by Section 73-30-3. A duly licensed clinical social worker shall be entitled to participate in such policies, plans or contracts providing for the diagnosis and treatment of mental, nervous or emotional disorders only as authorized by Section 73-53-3. A duly licensed marriage and family therapist shall be entitled to participate in such policies, plans or contracts providing for the diagnosis and treatment of mental, nervous or emotional disorders only as authorized by Section 73-54-5 et seq.

The addition of marriage and family therapists as providers herein is intended to only allow them to treat mental, nervous or emotional disorders as treated by other providers, to the extent that marriage and family therapists are qualified to treat such disorders. Notwithstanding anything in this section to the contrary, the scope or definition of mental, nervous or emotional disorders shall remain the same and shall not be expanded by the addition of marriage and family therapists as allowable providers.

HISTORY: Laws, 1974, ch. 514; Laws, 1992, ch. 586, § 1; reenacted and amended, Laws, 1994, ch. 327, § 1; reenacted and amended, Laws, 2005, ch. 493, § 1; Laws, 2008, ch. 318, § 1, eff from and after July 1, 2008.

RESEARCH REFERENCES

ALR.

What services, equipment, or supplies are "medically necessary" for purposes of coverage under medical insurance. 75 A.L.R.4th 763.

§ 83-41-213. Right of insureds or other beneficiaries to be reimbursed for services performed by physicians or nurse practitioners within lawful scope of their practice.

From and after January 1, 1999, whenever any policy of insurance or any medical service plan or hospital service contract or hospital and medical service contract issued, delivered, administered, continued or renewed in this state provides for reimbursement for any service which is within the lawful scope of practice of a duly certified nurse practitioner as provided for by rules and regulations implemented by the Mississippi Board of Nursing under Section 73-15-5(2), the insured or other person entitled to benefits under such policy shall be entitled to reimbursement for such services, whether such services are performed by a duly licensed physician or by a duly certified nurse practitioner, notwithstanding any provision to the contrary in any statute or in such policy, plan or contract. Duly certified nurse practitioners shall be entitled to participate in such policies, plans or contracts providing for the services of nurse practitioners, as authorized by the rules and regulations implemented by the Mississippi Board of Nursing under Section 73-15-5(2). Reimbursement shall be based on services rendered by a duly certified nurse practitioner.

It is the intent of the Legislature by this section to provide for increased access of health delivery services to the underserved.

HISTORY: Laws, 1979, ch. 469; reenacted, Laws, 1982, ch. 357, § 1; reenacted, Laws, 1984, ch. 330, § 1; reenacted Laws, 1988, ch. 422, § 1; reenacted Laws, 1988, ch. 412, § 1; Laws, 1999, ch. 326, § 2; Laws, 2009, ch. 474, § 3; Laws, 2010, ch. 315, § 3, eff from and after July 1, 2010.

Editor's Notes — Section 1 of Chapter 412, Laws of 1988, reenacted Section 83-41-213, effective from and after July 1, 1988 (approved by the Governor on April 23, 1988). Subsequently, Section 1, Chapter 422, Laws of 1988, also reenacted Section 83-41-213, effective upon passage, (approved by the Governor on April 23, 1988). The amendatory language in Chapters 412 and 422 is identical, and, by direction of the

Attorney General's Office of Mississippi, the effective date of July 1, 1988, has been inserted.

OPINIONS OF THE ATTORNEY GENERAL

Section 83-41-213(2) mandates that any all rules and/or regulations promulgated after March 28, 1995, relating to any activity of a nurse practitioner beyond the statutory definition of nursing must be adopted in identical form by both the Mississippi State Board of Medical Licensure and the Mississippi Board of Nursing, encompassed in orders spread upon the minutes of each board, and that such joint promulgation must comply with the provisions of the Mississippi Administrative Procedures Law, codified at §§ 25-43-1, et seq.; further, the Mississippi Board of Nursing may not adopt enforceable rules or regulations that impact the practice of nurse practitioners without the joint consent of the Mississippi State Board of Medical Licensure. Stevens, June 19, 1998, A.G. Op. #98-0354.

Any rules or regulations that impact the practice of nurse practitioners are to be jointly promulgated by the Mississippi Board of Nursing and the State Board of Medical Licensure. Perkins, Mar. 31, 2003, A.G. Op. #03-0060.

RESEARCH REFERENCES

ALR.

What services, equipment, or supplies are "medically necessary" for purposes of coverage under medical insurance. 75 A.L.R.4th 763.

Law Reviews.

1979 Mississippi Supreme Court Review: Insurance. 50 Miss. L. J. 813.

§ 83-41-214. Payment by third parties of certified nurse practitioners.

A policy or contract providing for third-party payment or prepayment of health or medical expenses shall include a provision for the payment of necessary medical or surgical care and treatment provided by a duly certified nurse practitioner and performed within the scope of the license of the certified nurse practitioner if the policy or contract would pay for the care and treatment if the care and treatment were provided by a person engaged in the practice of medicine and surgery or osteopathic medicine and surgery. The policy or contract shall provide that policyholders and subscribers under the policy or contract may reject the coverage for services which may be provided by a certified nurse practitioner if the coverage is rejected for all providers of similar services. A policy or contract subject to this section shall not impose a practice or supervision restriction which is inconsistent with or more restrictive than the restriction already imposed by law. This section applies to services provided under a policy or contract delivered, issued for delivery, continued, or renewed in this on or after July 1, 1999, and to an existing policy or contract, on the policy's or contract's anniversary or renewal date, whichever is later. This section does not apply to policyholders or subscribers eligible for coverage under Title XVIII of the federal Social Security Act or any similar coverage under a state or federal government plan. For the purposes of this section, third-party payment or prepayment includes an individual or group health care service contract, an individual or group health maintenance organization contract, or a preferred provider organization contract. Nothing in this section shall be interpreted to require an individual or group health maintenance organization, or a preferred provider organization to provide payment or prepayment for services provided by a certified nurse practitioner unless the certified nurse practitioner or the certified nurse practitioner's collaborating physician has entered into a contract or other agreement to provide services with the individual or group health maintenance organization or the preferred provider organization or arrangement.

HISTORY: Laws, 1999, ch. 326, § 1, eff from and after July 1, 1999.

Federal Aspects — Title XVIII of the Social Security Act, see 42 USCS §§ 1395 et seq.

§ 83-41-215. Right of beneficiary or insured to reimbursement for services performed by chiropractor; freedom of choice of practitioner and place of services.

Whenever any policy of insurance or any medical service plan or hospital service contract or hospital and medical service contract issued in this state provides for reimbursement for any service which is within the lawful scope of practice of a duly licensed chiropractor as defined in Section 73-6-1, Mississippi Code of 1972, then such service may be performed by a duly licensed chiropractor, and the insured or other person entitled to benefits under such policy, plan or contract shall be entitled to reimbursement for such services. The insured shall have the right to choose the place where the service is to be performed as well as the chiropractor to perform such service, provided that such service shall be performed in the chiropractor's office, clinic or regular place of business.

HISTORY: Laws, 1980, ch. 369, eff from and after passage (approved April 24, 1980).

Cross References — Accident and health insurance policy provisions, generally, see § 83-9-5.

JUDICIAL DECISIONS

1. In general.

Chiropractor claiming tortious interference and bad faith has standing to sue under § 83-41-215 for compensation; § 83-41-215 is not applicable to workers' compensation carrier, because §§ 71-3-9 and 71-3-15 clearly exclude chiropractic treatment unless it is approved by employer or carrier. Norville v. Commercial Union Ins. Co., 690 F. Supp. 558, 1988 U.S. Dist. LEXIS 8508 (S.D. Miss. 1988), aff'd, 866 F.2d 1419, 1989 U.S. App. LEXIS 1445 (5th Cir. Miss. 1989).

Claim by chiropractor that termination by workers' compensation insurance carrier of payments for chiropractic treatment state claims for tortious interference and bad faith, and are couched in terms so that they present case for plaintiff rather than claim for workers' compensation benefits, such that plaintiff has standing to sue under claims he has set forth, however, since workers' compensation laws specifically exclude chiropractic treatment as generally compensable, plaintiff does not have cause of action arising un-

der § 83-41-215. Norville v. Commercial Union Ins. Co., 690 F. Supp. 558, 1988 U.S. Dist. LEXIS 8508 (S.D. Miss. 1988), aff'd, 866 F.2d 1419, 1989 U.S. App. LEXIS 1445 (5th Cir. Miss. 1989).

Section 83-41-215, which provides in part that an insured shall have the right to choose a chiropractor and the place where chiropractic services are to be performed, does not prohibit an insurance company from drafting its medical payment clause to exclude coverage for chiropractic care, to include coverage for all chiropractic care, or to limit its coverage to only some chiropractic services. However, any company binding itself to cover chiropractic services brings itself under the dictates of the statute's mandatory freedom of choice provision. State Farm Mut. Auto. Ins. Co. v. Gregg, 526 So. 2d 554, 1988 Miss. LEXIS 308 (Miss. 1988).

The term "medical" in a medical payment provision of an insurance policy included healing arts in addition to the practice of medicine where the provision stated that coverage was provided for "necessary medical, surgical, x-ray, dental, ambulance, hospital, professional nursing, and funeral services, eyeglasses, hearing aids, and prosthetic devices." As used in the above-quoted portion of the provision, "medical" includes services or health care in addition to services provided by a physician. Thus, the insurance company was required to pay for reasonably necessary expenses for chiropractic care rendered to alleviate the effects of accidental bodily injury. State Farm Mut. Auto. Ins. Co. v. Gregg, 526 So. 2d 554, 1988 Miss. LEXIS 308 (Miss. 1988).

RESEARCH REFERENCES

ALR.

What services, equipment, or supplies are "medically necessary" for purposes of coverage under medical insurance. 75 A.L.R.4th 763.

Am. Jur.

44A Am. Jur. 2d, Insurance § 1590.

CJS.

45 C.J.S., Insurance § 1416.

§ 83-41-217. Direct access to obstetricians/gynecologists to be allowed; status as primary care physicians.

Any health care service plan contract that provides hospital, outpatient, medical or surgical coverage that is issued, amended, delivered or renewed in this state shall include obstetricians/gynecologists as primary care physicians and allow direct access to obstetricians/gynecologists by female patients if the obstetrician/gynecologist otherwise meets the policy or contract requirements.

HISTORY: Laws, 1995, ch. 514, § 1, eff from and after July 1, 1995.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 15, 28.
44 Am. Jur. 2d, Insurance § 1486.

CJS.

44 C.J.S., Insurance §§ 392 et seq.

§ 83-41-219. Reciprocal time limitations on health insurance claim filing and claim audits; applicability [See Editor's Notes for effective date and applicability].

(1) If any health insurance issuer or other health insurance benefit payer

limits the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer or other health insurance benefit payer shall have the same time limit following payment of the claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim.

(2) If any health insurance issuer or other health insurance benefit payer does not limit the time in which a health care provider or other person is required to submit a claim for payment, the health insurance issuer or other health insurance benefit payer may not request reimbursement or offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than twelve (12) months after the payment of an invalid or overpaid claim.

(3) Nothing in this section shall apply to:

(a) Audits that were opened before July 1, 2012;

(b) Audits of pharmacies as provided in Section 73-21-175 et seq.;

(c) Claims submitted by providers for reimbursement under the Mississippi Medicaid Program, except that all audits of claims and payments made by or on behalf of the Division of Medicaid are limited to a maximum of five (5) years after final filing of the claim; and

(d) Claims submitted in the context of misrepresentation, omission, concealment, or fraud by the health care provider or other person.

HISTORY: Laws, 2010, ch. 393, § 1; Laws, 2012, ch. 532, § 1, eff from and after July 1, 2012.

Editor's Notes — Laws of 2010, ch. 393, § 2 provides:

"SECTION 2. This act shall take effect and be in force from and after July 1, 2010, and shall apply to health care claims submitted for payment on or after that date."

Cross References — Mississippi Medicaid generally, see §§ 43-13-101 through 43-13-147.

ARTICLE 7.

HEALTH MAINTENANCE ORGANIZATION, PREFERRED PROVIDER ORGANIZATION AND OTHER PREPAID HEALTH BENEFIT PLANS PROTECTION ACT.

Sec.

83-41-301. Short title.
83-41-303. Definitions.
83-41-305. Requirement of certificate of authority for establishment and operation of health maintenance organization; filing, form and contents of application for certificate and attachments; qualification of foreign health maintenance organizations; effect of denial of certificate; rules and regulations.
83-41-307. Transmission of copies of application for certificate of authority to State Health Officer; duties of State Health Officer; grant or denial of certificate of authority.

Sec.
83-41-309. Powers of health maintenance organization generally; notice of exercise of powers affecting financial condition of organization.
83-41-311. Bonds or insurance for directors, officers, employees, partners and contractors.
83-41-313. Quality assurance procedures, programs and activities; maintenance and examination of patient records.
83-41-315. Filing, contents and approval of group and individual contracts and evidence of coverage.
83-41-317. Filing of annual reports, financial statements, etc.
83-41-319. Provision of information and notices to subscribers.
83-41-321. Grievance procedures.
83-41-323. Funds.
83-41-325. Minimum net worth requirement; deposits generally; computation of liabilities; contracts between health maintenance organizations and participating providers of services; insolvency plans.
83-41-327. Uncovered expenditures insolvency deposits.
83-41-329. Proceedings upon insolvency of health maintenance organization; terms and conditions of replacement coverage.
83-41-331. Premium rates.
83-41-333. Rules and regulations generally; exemptions from certification requirement.
83-41-335. Operation of health maintenance organizations by insurance companies and medical service corporations.
83-41-337. Examination of health maintenance organizations and providers; acceptance of reports in lieu of examinations.
83-41-339. Grounds and procedure for revocation, suspension or denial of certificate of authority; administrative penalty generally; correction of deficiencies in net worth; proceedings upon suspension or revocation of certificate of authority; appeals.
83-41-341. Rehabilitation, liquidation or administrative supervision of health maintenance organizations.
83-41-343. Remedies for correction of financial conditions of health maintenance organizations deemed hazardous to enrollees, creditors, or general public and violations of article.
83-41-345. Adoption of rules and regulations.
83-41-347. Fees.
83-41-349. Imposition of administrative penalties; informal proceedings for investigation and correction or prevention of violations; cease and desist orders.
83-41-351. Solicitation of enrollees.
83-41-353. Documents deemed public documents.
83-41-355. Confidentiality of data or information; claims of privilege; civil liability of members of health review committees; discovery of information considered by and records of health review committees; access to treatment records, etc., of enrollees.
83-41-357. Contracting authority of State Health Officer.
83-41-359. Acquisitions, mergers and consolidations of health maintenance organizations.
83-41-361. Adoption of coordination of benefits provisions.
83-41-363. Proceedings upon insolvency of health maintenance organization.
83-41-365. Contracting authority of commissioner.

§ 83-41-301. Short title.

This article may be cited as the Health Maintenance Organization, Preferred Provider Organization and Other Prepaid Health Benefit Plans Protection Act.

HISTORY: Laws, 1995, ch. 613, § 1, eff from and after July 1, 1995.

Cross References — Health maintenance organizations to comply with §§ 83-41-401 et seq. certification requirements, see § 83-41-411.

Applicability of article to Division of Medicaid in Office of Governor, see § 83-41-415.

RESEARCH REFERENCES

ALR.

Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

§ 83-41-303. Definitions.

(a) "Basic health care services" means the following medically necessary services: preventive care, emergency care, inpatient and outpatient hospital and physician care, diagnostic laboratory and diagnostic and therapeutic radiological services and includes but is not limited to mental health services or services for alcohol or drug abuse, dental or vision services or long-term rehabilitation treatment for the purpose of preventing, alleviating, curing or healing human illness or physical disability.

(b) "Capitated basis" means fixed per member per month payment or percentage of premium payment wherein the provider assumes the full risk for the cost of contracted services without regard to the type, value or frequency of services provided. Capitated basis includes the cost associated with operating staff model facilities.

(c) "Carrier" means a health maintenance organization, an insurer, a nonprofit hospital and medical service corporation, fraternal societies, preferred provider organizations or any other entity responsible for the payment of benefits or provision for services under a group contract or individual contract on a prepayment basis.

(d) "Commissioner" means the Commissioner of Insurance.

(e) "Copayment" means an amount an enrollee must pay in order to receive a specific service which is not fully prepaid.

(f) "Deductible" means the amount an enrollee is responsible to pay out-of-pocket before the carrier begins to be responsible for the costs associated with treatment.

(g) "Enrollee" means an individual who is covered for the benefits offered by the carrier.

(h) "Evidence of coverage" means a statement of the essential features and services of the health care provider which is given to the subscriber by the carrier or by the group contract holder.

(i) "Extension of benefits" means the continuation of coverage under a particular benefit provided under a contract following termination with respect to an enrollee or subscriber who is totally disabled on the date of termination.

(j) "Financing" means the prepayment of premium or premium equivalences for services to be received by the enrollee in the future together with acceptance and assumption of the risk, including capitation fee.

(k) "Grievance" means a written complaint submitted in accordance with the provider's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the carrier or provider to the enrolled.

(*l*) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specified group and may include coverage for dependents.

(m) "Group contract holder" means a person having a group contract.

(n) "Health maintenance organization" means any person that undertakes to provide or arrange for the delivery of basic health care services through an organized system which combines the delivery and financing of health care to enrollees on a prepaid or other financial basis (except for enrolled responsibility for copayment or deductibles) through an organized system which combines the delivery and financing of health care. When an organization accepts and assumes risks and accepts payments, fees, premiums or premium equivalences for that risk it is deemed to be a health maintenance organization.

(o) "Health maintenance organization producer" means a person who holds a life, health and accident insurance license and a certificate of authority to represent the health maintenance organization who solicits, negotiates, effects, procures, delivers, renews or continues a policy or contract for health maintenance organization membership, or who takes or transmits a membership fee or premium for such a policy or contract, other than for himself, or a person who advertises or otherwise holds himself out to the public as such.

(p) "Individual contract" means a contract for health care services issued to and covering an individual may include dependents of the subscriber.

(q) "Insolvent" or "Insolvency" means that the organization has been declared insolvent and placed under an order of rehabilitation or liquidation by a court of competent jurisdiction.

(r) "Managed hospital payment basis" means agreements wherein the financial risk is primarily related to the degree of utilization rather than to the cost of services.

(s) "Net worth" means the excess of total admitted assets over total liabilities, but the liabilities shall not include fully subordinated debt.

(t) "Participating provider" means a provider as defined in paragraph (v) who, under an express or implied contract with the health maintenance organization or with its contractor or subcontractor, has agreed to provide health care services to enrollees with an expectation of receiving payment, other than copayment or deductible, directly or indirectly from the health maintenance organization.

(u) "Person" means any natural or artificial person including but not limited to individuals, partnerships, associations, trusts, fraternal societies, or corporations.

(v) "Provider" means any physician, hospital or other person licensed or otherwise authorized to furnish health care services.

(w) "Replacement coverage" means the benefits provided by a succeeding carrier.

(x) "Subscriber" means an individual whose employment or other status, except family dependency, is the basis for eligibility for enrollment in the health maintenance organization, or in the case of an individual contract, the person in whose name the contract is issued.

(y) "Uncovered expenditures" means the costs to the health maintenance organization for health care services that are the obligation of the health maintenance organization, for which an enrollee may also be liable if the health maintenance organization is insolvent and for which no alternative arrangements have been made that are acceptable to the commissioner.

HISTORY: Laws, 1995, ch. 613, § 2, eff from and after July 1, 1995.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in paragraph (n). The words "accepts payments, fees, premiums or premium equivalences or that risk" were changed to "accepts payments, fees, premiums or premium equivalences for that risk."The Joint Committee ratified the correction at its May 20, 1998, meeting.

Cross References — Health maintenance organizations to comply with §§ 83-41-401 et seq. certification requirements, see § 83-41-411.

Duty of health maintenance organization to provide opportunities for participation by providers in geographic area, see § 83-41-417.

OPINIONS OF THE ATTORNEY GENERAL

Based on the lack of financing activities, particularly the lack of acceptance or assumption of the health care cost risk, a risk which is retained by the contracted benefits plan or insurer, an HMO is not deemed a "health maintenance organization" as defined in 83-41-303(n). Bean, December 20, 1996, A.G. Op. #96-0747.

§ 83-41-305. Requirement of certificate of authority for establishment and operation of health maintenance organization; filing, form and contents of application for certificate and attachments; qualification of foreign health maintenance organizations; effect of denial of certificate; rules and regulations.

(1) Notwithstanding any law of this state to the contrary, any person may apply to the commissioner for a certificate of authority to establish and operate a health maintenance organization in compliance with this article. No person shall establish or operate a health maintenance organization in this state, without obtaining a certificate of authority under this article. A foreign health maintenance organization may qualify under this article, subject to its registration to do business in this state as a foreign health maintenance organization under Section 79-4-15.01, Mississippi Code of 1972, and compliance with all provisions of this article and other applicable state laws.

(2) Any health maintenance organization which has not previously received a certificate of authority to operate as a health maintenance organiza-

tion as of July 1, 1995, shall submit an application for a certificate of authority under subsection (3) within sixty (60) days. Each applicant may continue to operate until the commissioner acts upon the application. If an application is denied under Section 83-41-307, the applicant shall thereafter be treated as a health maintenance organization whose certificate of authority has been revoked.

(3) Each application for a certificate of authority shall be verified by an officer or authorized representative of the applicant, shall be in a form prescribed by the commissioner, and shall set forth or be accompanied by the following:

(a) A copy of the organizational documents of the applicant, such as the articles of incorporation, articles of association, partnership agreement, trust agreement, or other applicable documents, and all amendments thereto;

(b) A copy of the bylaws, rules and regulations, or similar document, if any, regulating the conduct of the internal affairs of the applicant;

(c) A list of the names, addresses and official positions and biographical information on forms acceptable to the commissioner of the persons who are to be responsible for the conduct of the affairs and day to day operations of the applicant, including all members of the board of directors, board of trustees, executive committee or other governing board or committee and the principal officers in the case of a corporation, or the partners or members in the case of a partnership or association;

(d) A copy of any contract form made or to be made between any class of providers and the health maintenance organization and a copy of any contract made or to be made between third-party administrators, marketing consultants or persons listed in paragraph (c) and the health maintenance organization;

(e) A copy of the form of evidence of coverage to be issued to the enrollees;

(f) A copy of the form of group contract, if any, which is to be issued to employers, unions, trustees or other organizations;

(g) Financial statements showing the applicant's assets, liabilities and sources of financial support. Include both a copy of the applicant's most recent (regular) certified financial statement and an unaudited current financial statement;

(h) A financial feasibility plan which includes detailed enrollment projections, the methodology for determining premium rates to be charged during the first twelve months of operations certified by an actuary or other qualified person, a projection of balance sheets, cash flow statements showing any capital expenditures, purchase and sale of investments and deposits with the state, and income and expense statements anticipated from the start of operations until the organization has had net income for at least one (1) year, and a statement as to the sources of working capital as well as any other sources of funding;

(i) A power of attorney duly executed by the applicant, if not domiciled in this state, appointing the commissioner and his successors in office, and duly authorized deputies, as the true and lawful attorney of the applicant in and for this state upon whom all lawful process in any legal action or proceeding against the health maintenance organization on a cause of action arising in this state may be served;

(j) A statement or map reasonably describing the geographic area or areas to be served;

(k) A description of the internal grievance procedures to be utilized for the investigation and resolution of enrollee complaints and grievances;

(*l*) A description of the proposed quality assurance program, including the formal organizational structure, methods for developing criteria, procedures for comprehensive evaluation of the quality of care rendered to enrollees, and processes to initiate corrective action and reevaluation when deficiencies in provider or organizational performance are identified;

(m) A description of the procedures to be implemented to meet the protection against insolvency requirements in Section 83-41-325;

(n) A list of the names, addresses, and license numbers of all providers with which the health maintenance organization has agreements and this list must be updated at the end of each calendar quarter.

(o) Any other information as the commissioner may require to make the determinations required in Section 83-41-307.

(4)(a) The commissioner may promulgate rules and regulations as he deems necessary to the proper administration of this article to require a health maintenance organization and other entities subsequent to receiving its certificate of authority to submit the information, modifications or amendments to the items described in subsection (3) of this section to the commissioner, either for his approval or for information only, prior to the effectuation of the modification or amendment, or to require the health maintenance organization to indicate the modifications to both State Health Officer and commissioner at the time of the next succeeding site visit or examination.

(b) Any modification or amendment for which the commissioner's approval is required shall be deemed approved unless disapproved within thirty (30) days. The commissioner may postpone the action for a time, not exceeding an additional thirty (30) days, as necessary for proper consideration.

HISTORY: Laws, 1995, ch. 613, § 3, eff from and after July 1, 1995.

Cross References — Suspension or revocation of certificate of authority, see § 83-41-339.

RESEARCH REFERENCES

ALR.

Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

§ 83-41-307. Transmission of copies of application for certificate of authority to State Health Officer; duties of State Health Officer; grant or denial of certificate of authority.

(1)(a) Upon receipt of an application for issuance of a certificate of authority, the commissioner shall forthwith transmit copies of the application and accompanying documents to the State Health Officer.

(b) The State Health Officer shall determine whether the applicant for a certificate of authority, with respect to health care services to be furnished has complied with Section 83-41-313.

(c) Within forty-five (45) days of receipt of the application for issuance of a certificate of authority, the State Health Officer shall certify to the commissioner that the proposed health maintenance organization meets the requirements of Section 83-41-313 or notify the commissioner that the health maintenance organization does not meet the requirements and specify deficiencies.

(2) The commissioner shall within forty-five (45) days of receipt of certification or notice of deficiencies from the State Health Officer issue a certificate of authority to any person filing a completed application upon receiving the prescribed fees and upon the commissioner being satisfied that:

(a) The persons responsible for the conduct of the affairs of the applicant are competent, trustworthy and possess good reputations;

(b) Any deficiencies identified by the State Health Officer have been corrected and the State Health Officer has certified to the commissioner that the health maintenance organization's proposed plan of operation meets the requirements of Section 83-41-313 and other related regulations;

(c) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for copayments and/or deductibles; and

(d) The health maintenance organization is in compliance with Sections 83-41-325 and 83-41-329.

(3) A certificate of authority shall be denied only after the commissioner complies with the requirements of Section 83-41-339.

HISTORY: Laws, 1995, ch. 613, § 4, eff from and after July 1, 1995.

Cross References — Application for certificate of authority, see § 83-41-305.

Failure to meet requirements of this section as grounds for suspension or revocation of certificate of authority or denial of application for certificate, see § 83-41-339.

§ 83-41-309. Powers of health maintenance organization generally; notice of exercise of powers affecting financial condition of organization.

(1) The powers of a health maintenance organization include, but are not limited to, the following:

(a) The purchase, lease, construction, renovation, operation or maintenance of hospitals, medical facilities, or both, and their ancillary equipment, and any property as may reasonably be required for its principal office or for those purposes as may be necessary in the transaction of the business of the organization;

(b) Transactions between affiliated entities, including loans and the transfer of responsibility under all contracts between affiliates loans from the health maintenance organization to a parent are prohibited without prior approval in writing from the commissioner;

(c) The furnishing of health care services through providers, provider associations or agents for providers which are under contract with or employed by the health maintenance organization;

(d) The contracting with any person for the performance on its behalf of certain functions such as marketing, enrollment and administration provided all entities are qualified under this article;

(e) The contracting with an insurance company licensed in this state, or with a hospital or medical service corporation authorized to do business in this state, for the provision of insurance, indemnity or reimbursement against the cost of health care services provided by the health maintenance organization;

(f) The offering of other health care services, in addition to basic health care services. Non-basic health care services may be offered by a health maintenance organization on a prepaid basis without offering basic health care services to any group or individual;

(g) The joint marketing of products with an insurance company licensed in this state or with a hospital or medical service corporation authorized to do business in this state as long as the company that is offering each product is clearly identified.

(2)(a) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner prior to the exercise of any power granted in subsection 1(a), (b) or (d) which may affect the financial condition of the health maintenance organization. The commissioner shall disapprove an exercise of power only if in his opinion it would substantially and adversely affect the financial condition of the health maintenance organization and endanger its ability to meet its obligations.

(b) The commissioner may promulgate rules and regulations exempting from the filing requirement of paragraph (a) those activities having a de minimis effect.

HISTORY: Laws, 1995, ch. 613, § 5, eff from and after July 1, 1995.

Cross References — Investments, see 83-41-323.

RESEARCH REFERENCES

ALR.

Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

§ 83-41-311. Bonds or insurance for directors, officers, employees, partners and contractors.

(1) Any director, officer, employee, contractor or partner of a health maintenance organization who receives, collects, disburses or invests funds in connection with the activities of such organization shall be responsible for the funds in a fiduciary relationship to the organization.

(2) A health maintenance organization shall maintain in force a fidelity bond or fidelity insurance on employees and officers, directors and partners in an amount not less than Two Hundred Fifty Thousand Dollars ($250,000.00) for each health maintenance organization or a maximum of Five Million Dollars ($5,000,000.00) in aggregate maintained on behalf of health maintenance organizations owned by a common parent corporation, or such sum as may be prescribed by the commissioner.

HISTORY: Laws, 1995, ch. 613, § 6, eff from and after July 1, 1995.

RESEARCH REFERENCES

ALR.
Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

Am. Jur.
40 Am. Jur. 2d, Hospitals and Asylums §§ 6-13, 14-41.

CJS.
41 C.J.S., Hospitals §§ 11-14, 18-32, 33-44.

§ 83-41-313. Quality assurance procedures, programs and activities; maintenance and examination of patient records.

(1) The health maintenance organization shall establish procedures to assure that the health care services provided to enrollees shall be rendered under reasonable standards of quality of care consistent with prevailing professionally recognized standards of medical practice. The procedures shall include mechanisms to assure availability, accessibility and continuity of care.

(2) The health maintenance organization shall have an ongoing internal quality assurance program to monitor and evaluate its health care services, including primary and specialist physician services, and ancillary and preventive health care services, across all institutional and non-institutional settings. The program shall include, at a minimum, the following:

(a) A written statement of goals and objectives which emphasizes improved health status in evaluating the quality of care rendered to enrollees;

(b) A written quality assurance plan which describes the following:

(i) The health maintenance organization's scope and purpose in quality assurance;

(ii) The organizational structure responsible for quality assurance activities;

(iii) Contractual arrangements, where appropriate, for delegation of quality assurance activities;

(iv) Confidentiality policies and procedures;

(v) A system of ongoing evaluation activities;

(vi) A system of focused evaluation activities;

(vii) A system for credentialing providers and performing peer review activities; and

(viii) Duties and responsibilities of the designated physician responsible for the quality assurance activities.

(c) A written statement describing the system of ongoing quality assurance activities including:

(i) Problem assessment, identification, selection and study;

(ii) Corrective action, monitoring, evaluation and reassessment; and

(iii) Interpretation and analysis of patterns of care rendered to individual patients by individual providers;

(d) A written statement describing the system of focused quality assurance activities based on representative samples of the enrolled population which identifies method of topic selection, study, data collection, analysis, interpretation and report format; and

(e) Written plans for taking appropriate corrective action whenever, as determined by the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided.

(3) The organization shall record proceedings of formal quality assurance program activities and maintain documentation in a confidential manner. Quality assurance program minutes shall be available to the State Health Officer.

(4) The organization shall ensure the use and maintenance of an adequate patient record system which will facilitate documentation and retrieval of clinical information for the purpose of the health maintenance organization evaluating continuity and coordination of patient care and assessing the quality of health and medical care provided to enrollees.

(5) Enrollee clinical records shall be available to the State Health Officer or an authorized designee for examination and review to ascertain compliance with this section, or as deemed necessary by the State Health Officer.

(6) The organization shall establish a mechanism for periodic reporting of quality assurance program activities to the governing body, providers and appropriate organization staff.

HISTORY: Laws, 1995, ch. 613, § 7, eff from and after July 1, 1995.

Cross References — Investigation of applicants for certificate of authority by State Health Officer, see § 83-41-307.

Access to treatment records of enrollees, see § 83-41-355.

RESEARCH REFERENCES

ALR.
Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

Am. Jur.
40 Am. Jur. 2d, Hospitals and Asylums §§ 6, 26.

§ 83-41-315. Filing, contents and approval of group and individual contracts and evidence of coverage.

(1)(a) Every group and individual contract holder is entitled to a group or individual written contract respectively.

(b) The contract shall not contain provisions or statements which are unjust, unfair, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by the Unfair Trade Practices Act.

(c) The contract shall contain a clear statement of the following:

(i) Name and street address of the physical location of the home office of the health maintenance organization and telephone number;

(ii) Eligibility requirements;

(iii) Benefits and services within the service area;

(iv) Emergency care benefits and services;

(v) Out of area benefits and services (if any);

(vi) Copayments, deductibles or other out-of-pocket expenses;

(vii) Limitations and exclusions;

(viii) Enrollee termination;

(ix) Enrollee reinstatement (if any);

(x) Claims procedures;

(xi) Enrollee grievance procedures;

(xii) Continuation of coverage;

(xiii) Conversion;

(xiv) Extension of benefits (if any);

(xv) Coordination of benefits (if applicable);

(xvi) Subrogation (if any);

(xvii) Description of the service area;

(xviii) Entire contract provision;

(xix) Term of coverage;

(xx) Cancellation of group or individual contract holder;

(xxi) Renewal;

(xxii) Reinstatement of group or individual contract holder (if any);

(xxiii) Grace period; and

(xxiv) Conformity with state law, including but not limited to Section 83-9-1 et seq., Mississippi Code of 1972.

(2) In addition to those provisions required in subsection (1)(c), an individual contract shall provide for a ten-day (10-day) period to examine and return the contract and have the premium refunded. If services were received during the ten-day (10-day) period, and the person returns the contract to receive a refund of the premium paid, he or she must pay for the services.

(3)(a) Every subscriber shall receive an evidence of coverage from the group contract holder or the health maintenance organization.

(b) The evidence of coverage shall not contain provisions or statements which are unfair, unjust, inequitable, misleading, deceptive, or which encourage misrepresentation as defined by Unfair Trade Practices Act.

(c) The evidence of coverage shall contain a clear statement of the provisions required in subsection (1)(c).

(4) The commissioner may adopt regulations establishing readability standards for individual contract, group contract, and evidence of coverage forms.

(5) No group or individual contract, evidence of coverage or amendment thereto, shall be delivered or issued for delivery in this state, unless its form has been filed and the proper fees paid with and approved by the commissioner, subject to subsections (6) and (7) of this section.

(6) If an evidence of coverage issued pursuant to and incorporated in a contract issued in this state is intended for delivery in another state and the evidence of coverage has been approved for use in the state in which it is to be delivered, the evidence of coverage need not be submitted to the commissioner of this state for approval though it cannot be offered in this state without approval of the commissioner.

(7) Every form required by this section shall be filed for approval with the commissioner. At any time, after thirty (30) days' notice and for cause shown, the commissioner may withdraw approval of any form, effective at the end of the thirty (30) days. When a filing is disapproved or approval of a form is withdrawn, the commissioner shall give the health maintenance organization written notice of the reasons for disapproval and in the notice shall inform the health maintenance organization that within thirty (30) days of receipt of the notice the health maintenance organization may request a hearing. A hearing will be conducted within thirty (30) days after the commissioner has received the request for hearing.

(8) The commissioner may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this section.

HISTORY: Laws, 1995, ch. 613, § 8, eff from and after July 1, 1995.

Cross References — Suspension or revocation of certificate of authority, see § 83-41-339.

RESEARCH REFERENCES

ALR.

Constitutional right to jury trial in cause of action under state unfair or deceptive trade practices law. 54 A.L.R.5th 631.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 15, 28.

44A Am. Jur. 2d, Insurance §§ 1828-1856.

CJS.

45 C.J.S., Insurance § 601.

§ 83-41-317. Filing of annual reports, financial statements, etc.

(1) Every health maintenance organization shall annually, on or before the first day of March, file a report verified by at least two (2) principal officers with the commissioner, with a copy to the State Health Officer, covering the preceding calendar year. Such report shall be on and in accordance to the National Association of Insurance Commissioner's Annual Statement Blanks and Instruction thereto and the NAIC Accounting Practices and Procedures Manual. The health maintenance organization shall file by the first day of March of each year, unless otherwise stated:

(a) Audited financial statements on or before June 1;

(b) A list of the providers who have executed a contract that complies with Section 83-41-325(12); and

(c)(i) A description of the grievance procedures, and

(ii) The total number of grievances handled through such procedures, a compilation of the causes underlying those grievances, and a summary of the final disposition of those grievances.

(2) The commissioner may require such additional reports as are deemed necessary and appropriate to enable the commissioner to carry out his duties and responsibilities under this article.

HISTORY: Laws, 1995, ch. 613, § 9, eff from and after July 1, 1995.

Cross References — Documents deemed public documents, see § 83-41-353.

§ 83-41-319. Provision of information and notices to subscribers.

(1) The health maintenance organization shall provide to its subscribers a list of providers, upon enrollment, re-enrollment or at a minimum annually.

(2) Every health maintenance organization shall provide within thirty (30) days to its subscribers notice of any material change in the operation of the organization that will affect them directly.

(3) An enrollee must be notified in writing by the health maintenance organization of the termination of the primary care provider who provided health care services to that enrollee, if the plan operates on a formal gatekeeper concept. The health maintenance organization shall provide assistance to the enrollee in transferring to another participating primary care provider.

(4) The health maintenance organization shall provide to subscribers information on how services may be obtained, where additional information on access to services can be obtained and a number where the enrollee can contact the health maintenance organization, at no cost to the enrollee.

HISTORY: Laws, 1995, ch. 613, § 10, eff from and after July 1, 1995.

§ 83-41-321. Grievance procedures.

(1) Every health maintenance organization shall establish and maintain

a grievance procedure which has been approved by the commissioner, after consultation with the State Health Officer, to provide procedures for the resolution of grievances initiated by enrollees. The health maintenance organization shall maintain records regarding grievances received since the date of its last examination of such grievances.

(2) The commissioner or the State Health Officer may examine such grievance procedures.

HISTORY: Laws, 1995, ch. 613, § 11, eff from and after July 1, 1995.

Cross References — Suspension or revocation of certificate of authority, see § 83-41-339.

RESEARCH REFERENCES

ALR.

Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

§ 83-41-323. Funds.

With the exception of investments made in accordance with Section 83-41-309(1)(a), the funds of a health maintenance organization shall be invested only in accordance with investment permitted by the laws of the State of Mississippi for life insurance companies (Section 83-19-51 et seq., Mississippi Code of 1972).

HISTORY: Laws, 1995, ch. 613, § 12, eff from and after July 1, 1995.

RESEARCH REFERENCES

CJS.

41 C.J.S., Hospitals § 1.

§ 83-41-325. Minimum net worth requirement; deposits generally; computation of liabilities; contracts between health maintenance organizations and participating providers of services; insolvency plans.

(1) Before issuing any certificate of authority, the commissioner shall require that the health maintenance organization have an initial net worth of One Million Five Hundred Thousand Dollars ($1,500,000.00) and shall thereafter maintain the minimum net worth required under subsection (2).

(2) Except as provided in subsections (3) and (4) of this section, every health maintenance organization must maintain a minimum net worth equal to the greater of:

(a) One Million Dollars ($1,000,000.00); or

(b) Two percent (2%) of annual premium revenues as reported on the most recent annual financial statement filed with the commissioner on the first One Hundred Fifty Million Dollars ($150,000,000) of premium and one percent (1%) of annual premium on the premium in excess of One Hundred Fifty Million Dollars ($150,000,000.00); or

(c) An amount equal to the sum of three (3) months uncovered health care expenditures as reported on the most recent financial statement filed with the commissioner; or

(d) For a health maintenance organization in which seventy-five percent (75%) or more of the providers are paid on a capitated basis, an amount equal to the sum of:

(i) Eight percent (8%) of annual health care expenditures except those paid on a capitated basis or managed hospital payment basis as reported on the most recent financial statement filed with the commissioner; and

(ii) Four percent (4%) of annual hospital expenditures paid on a managed hospital payment basis as reported on the most recent financial statement filed with the commissioner.

(3) A health maintenance organization licensed before July 1, 1995 must maintain a minimum net worth of:

(a) Twenty-five percent (25%) of the amount required by subsection (2) by December 31, 1995;

(b) Fifty percent (50%) of the amount required by subsection (2) by December 31, 1996;

(c) Seventy-five percent (75%) of the amount required by subsection (2) by December 31, 1997;

(d) One hundred percent (100%) of the amount required by subsection (2) by December 31, 1998.

(4)(a) In determining net worth, no debt shall be considered fully subordinated unless the subordination clause is in a form acceptable to the commissioner. Any interest obligation relating to the repayment of any subordinated debt must be similarly subordinated.

(b) The interest expenses relating to the repayment of any fully subordinated debt shall be considered covered expenses.

(c) Any debt incurred by a note meeting the requirements of this section, and otherwise acceptable to the commissioner, shall not be considered a liability and shall be recorded as equity.

(5) Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner or, at the discretion of the commissioner, with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that are acceptable to him which at all times shall have a value of not less than Five Hundred Thousand Dollars ($500,000.00).

(6) A health maintenance organization that is in operation on July 1, 1995 shall make a deposit equal to Two Hundred Fifty Thousand Dollars ($250,000.00).

In the second year, the amount of the additional deposit for a health maintenance organization that is in operation on July 1, 1995 shall be equal to Two Hundred Fifty Thousand Dollars ($250,000.00), for a total of Five Hundred Thousand Dollars ($500,000.00).

(7) The deposit shall be an admitted asset of the health maintenance organization in the determination of net worth.

(8) All income from deposits shall be an asset of the organization. A health maintenance organization that has made a securities deposit may withdraw that deposit or any part thereof after making a substitute deposit of cash, securities, or any combination of these or other measures of equal amount and value. Any securities shall be approved by the commissioner before being deposited or substituted.

(9) The deposit shall be used to protect the interests of the health maintenance organization's enrollees and to assure continuation of health care services to enrollees of a health maintenance organization which is in rehabilitation or conservation. The commissioner may use the deposit for administrative costs directly attributable to a receivership or liquidation. If the health maintenance organization is placed in receivership or liquidation, the deposit shall be an asset subject to the provisions of the liquidation act.

(10) The commissioner may reduce or eliminate the deposit requirement if the health maintenance organization deposits with the state treasurer, commissioner, or other official body of the state or jurisdiction of domicile for the protection of all subscribers and enrollees, wherever located, of such health maintenance organization, cash, acceptable securities or surety, and delivers to the commissioner a certificate to such effect, duly authenticated by the appropriate state official holding the deposit.

(11) If the commissioner becomes aware of a need for additional deposits he may order a health maintenance organization to place with the State Treasurer additional deposits to meet the need to protect the securities.

(12) Every health maintenance organization shall, when determining liabilities, include an amount estimated in the aggregate to provide for any unearned premium and for the payment of all claims for health care expenditures which have been incurred, whether reported or unreported, which are unpaid and for which such organization is or may be liable, and to provide for the expense of adjustment or settlement of such claims, and guaranteed renewal reserves if applicable.

The liabilities shall be computed in accordance with regulations promulgated by the commissioner upon reasonable consideration of the ascertained experience and character of the health maintenance organization.

(13) Every contract between a health maintenance organization and a participating provider of health care services shall be in writing and shall set forth that if the health maintenance organization fails to pay for health care services as set forth in the contract, the subscriber or enrollee shall not be liable to the provider for any sums owed by the health maintenance organization.

(14) If the participating provider contract has not been reduced to writing as required or that the contract fails to contain the required prohibition, the participating provider shall not collect or attempt to collect from the subscriber or enrollee sums owed by the health maintenance organization.

(15) No participating provider, or agent, trustee or assignee thereof, may

maintain any action at law against a subscriber or enrollee to collect sums owed by the health maintenance organization.

(16) The commissioner shall require that each health maintenance organization have a plan for handling insolvency which allows for continuation of benefits for the duration of the contract period for which premiums have been paid and continuation of benefits to members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits. The commissioner in his discretion may require:

(a) Insurance to cover the expenses to be paid for continued benefits after an insolvency;

(b) Provisions in provider contracts that obligate the provider to provide services for the duration of the period after the health maintenance organization's insolvency for which premium payment has been made and until the enrollees' discharge from inpatient facilities;

(c) Insolvency reserves;

(d) Acceptable letters of credit;

(e) Any other arrangements to assure that benefits are continued as specified above.

(17) An agreement to provide health care services between a provider and a health maintenance organization must require that if the provider terminates the agreement, the provider shall give the health maintenance organization at least sixty (60) days' advance notice of termination.

HISTORY: Laws, 1995, ch. 613, § 13, eff from and after July 1, 1995.

Cross References — Insurers Rehabilitation and Liquidation Act, see §§ 83-24-1 et seq.

Applications for certificates of authority, see § 83-41-305.

Grant or denial of certificate of authority, see § 83-41-307.

Reports, see § 83-41-317.

Uncovered expenditures insolvency deposit, see § 83-41-327.

Failure to correct deficiency in minimum net worth required by this section as grounds for suspension or revocation of certificate of authority or denial of application for certificate, see § 83-41-339.

Rehabilitation, liquidation or supervision, see § 83-41-341.

RESEARCH REFERENCES

ALR.

Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

§ 83-41-327. Uncovered expenditures insolvency deposits.

(1) If at any time uncovered expenditures exceed ten percent (10%) of total health care expenditures, a health maintenance organization shall place an uncovered expenditures insolvency deposit with the commissioner, with any organization or trustee acceptable to the commissioner through which a custodial or controlled account is maintained, cash or securities that are acceptable to the commissioner. The deposit shall at all times have a fair market value in an amount of one hundred twenty percent (120%) of the health

maintenance organization's outstanding liability for uncovered expenditures for enrollees in this state, including incurred but not reported claims, and shall be calculated as of the first day of the month and maintained for the remainder of the month. If a health maintenance organization is not otherwise required to file a quarterly report, it shall file a report within forty-five (45) days of the end of the calendar quarter with information sufficient to demonstrate compliance with this section.

(2) The deposit required under this section is in addition to the deposit required in Section 83-41-325 and is an admitted asset (as defined under insurance law) of the health maintenance organization in the determination of net worth. All income from deposits or trust accounts shall be assets of the health maintenance organization and may be withdrawn from such deposit or account quarterly with the approval of the commissioner.

(3) A health maintenance organization that has made a deposit may withdraw that deposit or any part of the deposit if: (a) a substitute deposit of cash or securities of equal amount and value is made, (b) the fair market value exceeds the amount of the required deposit, or (c) the required deposit under subsection (1) is reduced or eliminated. Deposits, substitutions or withdrawals may be made only with the prior written approval of the commissioner.

(4) The deposit required under this section is in trust and may be used only as provided under this section. The commissioner may use the deposit of an insolvent health maintenance organization for administrative costs associated with administering the deposit and payment of claims of enrollees of this state for uncovered expenditures in this state. Claims for uncovered expenditures shall be paid on a pro rata basis based on assets available to pay ultimate liability for incurred expenditures. Partial distribution may be made pending final distribution. Any amount of the deposit remaining may be paid into the liquidation or receivership of the health maintenance organization.

(5) The commissioner may by regulation prescribe the time, manner and form for filing claims under subsection (4).

(6) The commissioner may by regulation or order require health maintenance organizations to file annual, quarterly or more frequent reports as he deems necessary to demonstrate compliance with this section. The commissioner may require that the reports include liability for uncovered expenditures as well as an audit opinion.

HISTORY: Laws, 1995, ch. 613, § 14, eff from and after July 1, 1995.

§ 83-41-329. Proceedings upon insolvency of health maintenance organization; terms and conditions of replacement coverage.

(1) In the event of an insolvency of a health maintenance organization, upon order of the commissioner all other carriers that participated in the enrollment process with the insolvent health maintenance organization at a group's last regular enrollment period shall offer such group's enrollees of the insolvent health maintenance organization a thirty-day enrollment period

commencing upon the date of insolvency. Each carrier shall offer such enrollees of the insolvent health maintenance organization the same coverages and rates that it had offered to the enrollees of the group at its last regular enrollment period.

(2) If no other carrier had been offered to some groups enrolled in the insolvent health maintenance organization, or if the commissioner determines that the other health benefit plans lack sufficient health care delivery resources to assure that health care services will be available and accessible to all of the group enrollees of the insolvent health maintenance organization, then the commissioner shall allocate equitably the insolvent health maintenance organization's group contracts for those groups among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each health maintenance organization. Each health maintenance organization to which a group or groups are so allocated shall offer the group or groups the health maintenance organization's existing coverage which is most similar to each group's coverage with the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. The commissioner in his sole discretion addresses reasonableness.

(3) The commissioner shall also allocate equitably the insolvent health maintenance organization's nongroup enrollees which are unable to obtain other coverage among all health maintenance organizations which operate within a portion of the insolvent health maintenance organization's service area, taking into consideration the health care delivery resources of each such health maintenance organization. Each health maintenance organization to which nongroup enrollees are allocated shall offer such nongroup enrollees the health maintenance organization's existing coverage for individual or conversion coverage as determined by his type of coverage in the insolvent health maintenance organization at rates determined in accordance with the successor health maintenance organization's existing rating methodology. Successor health maintenance organizations which do not offer direct nongroup enrollment may aggregate all of the allocated nongroup enrollees into one group for rating and coverage purposes. The commissioner in his sole discretion addresses reasonableness.

(4) "Discontinuance" means the termination of the contract between the group contract holder and a health maintenance organization due to the insolvency of the health maintenance organization, and does not refer to the termination of any agreement between any individual enrollee and the health maintenance organization.

(5) Any carrier providing replacement coverage with respect to group hospital, medical or surgical expense or service benefits within a period of sixty (60) days from the date of discontinuance of a prior health maintenance organization contract or policy providing hospital, medical or surgical expense or service benefits shall immediately cover all enrollees who were validly covered under the previous health maintenance organization contract or policy

at the date of discontinuance and who would otherwise be eligible for coverage under the succeeding carrier's contract, regardless of any provisions of the contract relating to active employment or hospital confinement or pregnancy.

(6) Except to the extent benefits for the condition would have been reduced or excluded under the prior carrier's contract or policy, no provision in a succeeding carrier's contract of replacement coverage which would operate to reduce or exclude benefits on the basis that the condition giving rise to benefits preexisted the effective date of the succeeding carrier's contract shall be applied with respect to those enrollees validly covered under the prior carrier's contract or policy on the date of discontinuance.

HISTORY: Laws, 1995, ch. 613, § 15, eff from and after July 1, 1995.

Cross References — Grant or denial of certificate of authority, see § 83-41-307.
Revocation or suspension of certificate of authority, see § 83-41-339.
Proceedings upon insolvency, see § 83-41-363.

§ 83-41-331. Premium rates.

(1) No premium rate may be used until either a schedule of premium rates or methodology for determining premium rates has been filed with and approved by the commissioner.

(2) Either a specific schedule of premium rates, or a methodology for determining premium rates, shall be established in accordance with actuarial principles for various categories of enrollees, provided that the premium applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. However, the premium rates shall not be excessive, inadequate or unfairly discriminatory. A certification by a qualified actuary or other qualified person acceptable to the commissioner as to the appropriateness of the use of the methodology, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

(3) The commissioner shall approve the schedule of premium rates or methodology for determining premium rates if the requirements of subsection (2) are met. If the commissioner disapproves the filing, he shall notify the health maintenance organization. In the notice, the commissioner shall specify the reasons for his disapproval. A hearing will be conducted within thirty (30) days after a request in writing by the person filing.

HISTORY: Laws, 1995, ch. 613, § 16, eff from and after July 1, 1995.

Cross References — Using schedule of charges for health care services that do not comply with requirements of this section as grounds for suspension or revocation of certificate of authority or denial of application for certificate, see § 83-41-339.

§ 83-41-333. Rules and regulations generally; exemptions from certification requirement.

(1) The commissioner may, after notice and hearing, promulgate rules and regulations as are necessary to provide for the licensing of health maintenance organization producers. The rules shall establish:

(a) The requirements for licensure of resident health maintenance organization producers;

(b) The conditions for entering into reciprocal agreements with other jurisdictions for the licensure of nonresident health maintenance organization producers;

(c) Any examination, prelicensing or continuing education requirements;

(d) The requirements for registering and terminating the appointment of health maintenance organization producers;

(e) Any requirements for registering any assumed names or office locations in which an health maintenance organization producer does business;

(f) The conditions for health maintenance organization producer license renewal;

(g) The grounds for denial, refusal, suspension or revocation of an health maintenance organization producer's license;

(h) Any required fees for the licensing activities of health maintenance organization producers; and

(i) Any other requirement or procedure and any form as may be reasonably necessary to provide for the effective administration of the licensing of health maintenance organization producers under this section.

(2) The commissioner may by rule exempt certain classes of persons from the requirement of obtaining a license:

(a) If the functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or

(b) If other existing safeguards make regulation unnecessary.

HISTORY: Laws, 1995, ch. 613, § 17, eff from and after July 1, 1995.

Cross References — Adoption of rules and regulations, see § 83-41-345.

§ 83-41-335. Operation of health maintenance organizations by insurance companies and medical service corporations.

(1) An insurance company licensed in this state, or a hospital or medical service corporation authorized to do business in this state, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this article. Any two (2) or more insurance companies, hospital or medical service corporations, or subsidiaries or affiliates, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof, which health maintenance organization shall be subject to the provisions of this article.

(2) Notwithstanding any provision of insurance and hospital or medical service corporation laws, an insurer or a hospital or medical service corpora-

tion may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage if the health maintenance organization fails to meet its obligations.

The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under the contracts, the insurer or hospital or medical service corporation may make benefit payments to health maintenance organizations for health care services rendered by providers.

HISTORY: Laws, 1995, ch. 613, § 18, eff from and after July 1, 1995.

§ 83-41-337. Examination of health maintenance organizations and providers; acceptance of reports in lieu of examinations.

(1) The commissioner shall make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every five (5) years at the expense of the health maintenance organization and provider with whom the health maintenance organization has contracted according to relevant statutes which govern examinations of insurance companies under the insurance laws of this state.

(2) The State Health Officer may make an examination concerning the quality assurance program of the health maintenance organization and of any providers with whom such organization has contracts, agreements or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this state but not less frequently than once every five (5) years.

(3) Every health maintenance organization and provider shall submit its books and records for such examinations and in every way facilitate the completion of the examination. For the purpose of examinations, the commissioner and the State Health Officer may administer oaths to, and examine the officers and agents of, the health maintenance organization and the principals of providers concerning their business as per existing insurance laws, rules and regulations.

(4) The expenses of examinations under this section shall be assessed against the health maintenance organization being examined as per existing laws for examination of insurance companies or the State Health Officer for whom the examination is being conducted.

(5) In lieu of such examination, the commissioner or State Health Officer may accept the report of an examination made by the Commissioner of Insurance or the State Health Officer of another state.

HISTORY: Laws, 1995, ch. 613, § 19; Laws, 2012, ch. 364, § 3, eff from and after July 1, 2012.

§ 83-41-339. Grounds and procedure for revocation, suspension or denial of certificate of authority; administrative penalty generally; correction of deficiencies in net worth; proceedings upon suspension or revocation of certificate of authority; appeals.

(1) Any certificate of authority issued under this article may be suspended or revoked, and any application for a certificate of authority may be denied, if the commissioner after a hearing finds that any of the conditions listed below exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document or in a manner contrary to that described in any other information submitted under Section 83-41-305, unless amendments to the submissions have been filed with and approved by the commissioner;

(b) The health maintenance organization issues an evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of Sections 83-41-315 and 83-41-331;

(c) The health maintenance organization does not provide or arrange for basic health care services;

(d) The State Health Officer certifies to the commissioner that:

(i) The health maintenance organization does not meet the requirements of Section 83-41-307(1)(b); or

(ii) The health maintenance organization is unable to fulfill its obligations to furnish health care services;

(e) The health maintenance organization operating in a "hazardous condition", and is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to correct, within the time prescribed by subsection (3), any deficiency occurring due to such health maintenance organization's prescribed minimum net worth being impaired;

(g) The health maintenance organization has failed to implement the grievance procedures required by Section 83-41-321 in a reasonable manner to resolve valid complaints;

(h) The health maintenance organization, or any person on its behalf, has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees; or

(j) The health maintenance organization has otherwise failed substantially to comply with this article.

(2) In addition to or in lieu of suspension or revocation of a certificate of authority pursuant to this section, the applicant or health maintenance organization may be subjected to an administrative penalty of up to One Thousand Dollars ($1,000.00) for each violation.

(3) The following shall pertain when insufficient net worth is maintained:

(a) Whenever the commissioner finds that the net worth maintained by any health maintenance organization subject to the provisions of this article is less than the minimum net worth required to be maintained by Section 83-41-325, he shall give written notice to the health maintenance organization of the amount of the deficiency and require: (i) filing with the commissioner a plan for correction of the deficiency acceptable to the commissioner and (ii) correction of the deficiency within a reasonable time, not to exceed sixty (60) days, unless an extension of time, not to exceed sixty (60) additional days, is granted by the commissioner. The deficiency shall be deemed an impairment, and failure to correct the impairment in the prescribed time shall be grounds for suspension or revocation of the certificate of authority or for placing the health maintenance organization in administrative supervision, rehabilitation or liquidation as per the insurance laws of this State.

(b) Unless allowed by the commissioner no health maintenance organization or person acting on its behalf may, directly or indirectly, renew, issue or deliver any certificate, agreement or contract of coverage in this state, for which a premium is charged or collected, when the health maintenance organization writing such coverage is impaired, and the fact of such impairment is known to the health maintenance organization or to such person.

However, the existence of an impairment shall not prevent the issuance or renewal of a certificate, agreement or contract when the enrollee exercises an option granted under the plan to obtain a new, renewed or converted coverage.

(4) A certificate of authority shall be suspended or revoked or an application or a certificate of authority denied or an administrative penalty imposed only after compliance with the requirements of this section.

(a) Suspension or revocation of a certificate of authority or the denial of an application or the imposition of an administrative penalty pursuant to this section shall be by written order and shall be sent to the health maintenance organization or applicant by certified or registered mail and to the State Health Officer. The written order shall state the grounds, charges or conduct on which suspension, revocation or denial or administrative penalty is based. The health maintenance organization or applicant may in writing request a hearing within twenty-day (20) days from the date of mailing of the order. The said request must be filed with the commissioner within the twenty-day (20-day) period. If no written request is made, such order shall be final upon the expiration of said twenty (20) days.

(b) If the health maintenance organization or applicant requests a hearing pursuant to this section, the commissioner shall issue a written notice of hearing and send it to the health maintenance organization or applicant by certified or registered mail and to the State Health Officer stating:

(i) A specific time for the hearing, which may not be less than twenty (20) days after mailing of the notice of hearing; and

(ii) A specific place for the hearing which shall be at the discretion of the commissioner and which may be either in Jackson, Hinds County, Mississippi or in the county where the health maintenance organization's or applicant's principal place of business is located.

(iii) If a hearing is requested, the State Health Officer or his designated representative shall be in attendance and shall participate in the proceedings. The recommendations and findings of the State Health Officer with respect to matters relating to the quality of health care services provided in connection with any decision regarding denial, suspension or revocation of a certificate of authority, shall be conclusive and binding upon the commissioner.

After the hearing, or upon failure of the health maintenance organization to appear at the hearing, the commissioner shall take whatever action he deems necessary based on written findings and shall mail his decision to the health maintenance organization or applicant with a copy to the State Health Officer. The action of the commissioner and the recommendation and findings of the State Health Officer shall be subject to review under the Administrative Rules of Practice and Procedure Act.

(5) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(6) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization under supervision of the commissioner. It shall engage in no further advertising or solicitation whatsoever. The commissioner may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

(7) Any appeal from a decision of the commissioner under this section shall be to the Chancery Court of the First Judicial District of Hinds County, Mississippi within thirty days (30) from the final Order of the commissioner.

HISTORY: Laws, 1995, ch. 613, § 20, eff from and after July 1, 1995.

Cross References — Mississippi Administrative Procedures Law, see §§ 25-43-1.101 et seq.

Administrative penalties in lieu of suspension or revocation of certificate of authority, see § 83-41-349.

§ 83-41-341. Rehabilitation, liquidation or administrative supervision of health maintenance organizations.

(1) Any rehabilitation, liquidation or administrative supervision of a health maintenance organization shall be deemed to be the same as the

rehabilitation, liquidation or administrative supervision of an insurance company and shall be conducted under the supervision of the commissioner pursuant to the law governing the rehabilitation, liquidation, and administrative supervision of insurance companies. The commissioner may apply for an order directing him to rehabilitate or liquidate a health maintenance organization upon any one or more grounds set out in Section 83-41-325 or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) For purpose of determining the priority of distribution of general assets, claims of enrollees and enrollees' beneficiaries shall have the same priority as established by the Rehabilitation and Liquidation Act (Section 83-24-1 et seq., Mississippi Code of 1972) for policyholders and beneficiaries of insureds of insurance companies. If an enrollee is liable to any provider for services provided pursuant to and covered by the health care plan, that liability shall have the status of an enrollee claim for distribution of general assets.

(3) Any provider who is obligated by statute or agreement to hold enrollees harmless from liability for services provided pursuant to and covered by a health care plan shall have a priority of distribution of the general assets immediately following that of enrollees and enrollees' beneficiaries as described herein, and immediately preceding the priority of distribution described in Section 83-24-1 et seq., Mississippi Code of 1972.

HISTORY: Laws, 1995, ch. 613, § 21, eff from and after July 1, 1995.

§ 83-41-343. Remedies for correction of financial conditions of health maintenance organizations deemed hazardous to enrollees, creditors, or general public and violations of article.

(1) Whenever the commissioner determines that the financial condition of any health maintenance organization is such that its continued operation might be hazardous to its enrollees, creditors, or the general public, or that it has violated any provision of this article, he may, after notice and hearing, order the health maintenance organization to take such action as may be reasonably necessary to rectify such condition or violation, including but not limited to one or more of the following:

(a) Reduce the total amount of present and potential liability for benefits by reinsurance or other method acceptable to the commissioner;

(b) Reduce the volume of new business being accepted;

(c) Reduce expenses by specified methods;

(d) Suspend or limit the writing of new business for a period of time;

(e) Increase the health maintenance organization's capital and surplus by contribution; or

(f) Take such other steps as the commissioner may deem appropriate under the circumstances.

(2) For purposes of this section, the violation by a health maintenance organization of any law of this state to which such health maintenance organization is subject shall be deemed a violation of this article.

(3) The commissioner is authorized, by rules and regulations, to set uniform standards and criteria for early warning that the continued operation of any health maintenance organization might be hazardous to its enrollees, creditors, or the general public and to set standards for evaluating the financial condition of any health maintenance organization, which standards shall be consistent with the purposes expressed in subsection (1) of this section.

(4) The remedies and measures available to the commissioner under this section shall be in addition to, and not in lieu of, the remedies and measures available to the commissioner under the provisions of the insurance laws of the State of Mississippi.

HISTORY: Laws, 1995, ch. 613, § 22, eff from and after July 1, 1995.

§ 83-41-345. Adoption of rules and regulations.

The commissioner may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to carry out the provisions of this article.

HISTORY: Laws, 1995, ch. 613, § 23, eff from and after July 1, 1995.

§ 83-41-347. Fees.

(1) Every health maintenance organization subject to this article shall pay to the commissioner the following fees:

(a) For filing an application for a certificate of authority for a health maintenance organization and amendment thereto $5,000.00;
(b) For filing an amendment to the organization documents that requires approval ....$ 50.00;
(c) For filing an amendment "for information only" ....$ 25.00;
(d) For filing each annual report ....$ 500.00;
(e) Annual renewal of Certificate of Authority ....$ 500.00;
(f) Policy forms, certificates, endorsements, riders, applications and rates ....$ 15.00;

(2) The State Health Officer may utilize state employees or he may contract with other persons, companies, corporations and entities to carry out the duties and responsibilities under this article. If it is necessary to contract for the performance of the duties and responsibilities required under this article, the expense for the services shall be charged to the carrier and paid directly to the contracting party. The charge shall be approved by the State Health Officer prior to the services being rendered when sufficient information

is available to the State Health Officer, though the carrier is responsible for all charges expended when additional services are necessary to carry out the duties and responsibilities for finalization of the licensing process. The method and procedure for the payment of the expenses may be addressed in the regulations promulgated under this article.

HISTORY: Laws, 1995, ch. 613, § 24, eff from and after July 1, 1995.

Cross References — Administrative penalties in lieu of suspension or revocation of certificate of authority, see § 83-41-349.

§ 83-41-349. Imposition of administrative penalties; informal proceedings for investigation and correction or prevention of violations; cease and desist orders.

(1) The commissioner may, in lieu of suspension or revocation of a certificate of authority under Section 83-41-339, levy an administrative penalty in an amount not less than One Hundred Dollars ($100.00) per violation, nor more than One Thousand Dollars ($1,000.00) per violation, if reasonable; notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

(2)(a) If the commissioner or the State Health Officer shall for any reason have cause to believe that any violation of this article has occurred or is threatened, the commissioner or State Health Officer may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in the suspected violation, to arrange a hearing with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to the suspected violation; and, if it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing the violation.

(b) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner or the State Health Officer may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section of this article are satisfied.

(3)(a) The commissioner may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this article.

(b) Within ten (10) days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this article have occurred. The hearings shall be conducted pursuant to rules of practice and procedure before the Mississippi Insurance Department and judicial review shall be available as provided by Section 83-41-339.

(4) In the case of any violation of the provisions of this article, if the commissioner elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to subsection (3), the commissioner may institute a proceeding to obtain injunctive or other appropriate relief in the Chancery Court of the First Judicial District of Hinds County, Jackson, Mississippi.

(5) Notwithstanding any other provisions of this article, if a health maintenance organization fails to comply with the net worth requirement of this article, the commissioner is authorized to take appropriate action to assure that the continued operation of the health maintenance organization will not be hazardous to its enrollees.

HISTORY: Laws, 1995, ch. 613, § 25, eff from and after July 1, 1995.

§ 83-41-351. Solicitation of enrollees.

(1) This provision shall not apply to an insurer or hospital or medical service corporation licensed and regulated pursuant to the insurance law or the hospital or medical service corporation laws of this state except with respect to its health maintenance organization activities authorized and regulated pursuant to this article.

(2) Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, shall not be construed to violate any provision of law relating to solicitation or advertising by health professionals.

HISTORY: Laws, 1995, ch. 613, § 26, eff from and after July 1, 1995.

§ 83-41-353. Documents deemed public documents.

All applications, filings and reports required under this article shall be treated as public documents, except those which are trade secrets or privileged or confidential quality assurance, commercial or financial information, other than any annual financial statement that may be required under Section 83-41-317.

HISTORY: Laws, 1995, ch. 613, § 27, eff from and after July 1, 1995.

§ 83-41-355. Confidentiality of data or information; claims of privilege; civil liability of members of health review committees; discovery of information considered by and records of health review committees; access to treatment records, etc., of enrollees.

(1) Any data or information pertaining to the diagnosis, treatment or health of any enrollee or applicant obtained from the person or from any provider by any

health maintenance organization shall be held in confidence and shall not be disclosed to any person except to the extent that it may be necessary to carry out the purposes of this article; or upon the express consent of the enrollee or applicant; or pursuant to statute or court order for the production of evidence or the discovery thereof; or in the event of claim or litigation between the person and the health maintenance organization wherein the data or information is pertinent. A health maintenance organization shall be entitled to claim any statutory privileges against disclosure which the provider who furnished information to the health maintenance organization is entitled to claim.

(2) A person who, in good faith and without malice, takes any action or makes any decision or recommendation as a member, agent or employee of a health care review committee or who furnishes any records, information or assistance to a committee shall not be subject to liability for civil damages or any legal action in consequence of the action, nor shall the health maintenance organization which established a committee or the officers, directors, employees or agents of the health maintenance organization be liable for the activities of the person. This section shall not be construed to relieve any person of liability arising from treatment of a patient.

(3)(a) The information considered by a health care review committee and the records of their actions and proceedings shall be confidential and not subject to subpoena or order to produce except in proceedings before the appropriate state licensing or certifying agency, or in an appeal, if permitted, from the committee's findings or recommendations. No member of a health care review committee, or officer, director or other member of a health maintenance organization or its staff engaged in assisting a committee, or any person assisting or furnishing information to a committee may be subpoenaed to testify in any judicial or quasi-judicial proceeding if the subpoena is based solely on such activities.

(b) Information considered by a health care review committee and the records of its actions and proceedings which are used pursuant to subsection (3)(a) by a state licensing or certifying agency or in an appeal shall be kept confidential and shall be subject to the same provision concerning discovery and use in legal actions as are the original information and records in the possession and control of a health care review committee.

(4) To fulfill its obligations under Section 83-41-313, the health maintenance organization shall have access to treatment records and other information pertaining to the diagnosis, treatment or health status of any enrollee.

HISTORY: Laws, 1995, ch. 613, § 28, eff from and after July 1, 1995.

RESEARCH REFERENCES

ALR.

Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

Waiver of evidentiary privilege by inadvertent disclosure–state law. 51 A.L.R.5th 603.

§ 83-41-357. Contracting authority of State Health Officer.

The State Health Officer in carrying out his obligations under this article, may contract with qualified persons to make recommendations concerning the determinations required to be made by him. The recommendations may be accepted in full or in part by the State Health Officer.

HISTORY: Laws, 1995, ch. 613, § 29, eff from and after July 1, 1995.

§ 83-41-359. Acquisitions, mergers and consolidations of health maintenance organizations.

No person may make a tender for or a request or invitation for tenders of, or enter into an agreement to exchange securities for or acquire in the open market or otherwise, any voting security of a health maintenance organization or enter into any other agreement if, after the consummation thereof, that person would, directly or indirectly, (or by conversion or by exercise of any right to acquire) be in control of the health maintenance organization, and no person may enter into an agreement to merge or consolidate with or otherwise to acquire control of a health maintenance organization, unless, at the time any offer, request or invitation is made or any agreement is entered into, or prior to the acquisition of the securities if no offer or agreement is involved, the person has filed with the commissioner and has sent to the health maintenance organization, information required by the commissioner substantially similar to the information required pursuant to Section 83-6-1 et seq., Mississippi Code of 1972, and the offer, request, invitation, agreement or acquisition has been approved by the commissioner.

HISTORY: Laws, 1995, ch. 613, § 30, eff from and after July 1, 1995.

§ 83-41-361. Adoption of coordination of benefits provisions.

(1) Health maintenance organizations are permitted, but not required, to adopt coordination of benefits provisions to avoid overinsurance and to provide for the orderly payment of claims when a person is covered by two (2) or more group health insurance or health care plans.

(2) To the extent necessary for health maintenance organizations to meet their obligations as secondary carriers under the rules for coordination, health maintenance organizations shall make payments for services that are covered under the terms of their group contracts or evidence of coverage.

HISTORY: Laws, 1995, ch. 613, § 31, eff from and after July 1, 1995.

§ 83-41-363. Proceedings upon insolvency of health maintenance organization.

(1) When a health maintenance organization in this state is declared

insolvent by a court of competent jurisdiction, the commissioner may levy an assessment on health maintenance organizations doing business in this state to pay claims for uncovered expenditures for enrollees who are residents of this state and to provide continuation of coverage for subscribers or enrollees not covered under Section 83-41-329. The commissioner may not assess in any one (1) calendar year more than two percent (2%) of the aggregate premium written by each health maintenance organization in this state the prior calendar year.

(2)(a) The commissioner may use funds obtained under subsection (1) to pay claims for uncovered expenditures for subscribers or enrollees of an insolvent health maintenance organization who are residents of this state, provide for continuation of coverage for subscribers or enrollees who are residents of this state and are not covered under Section 83-41-329, and administrative costs. The commissioner may by regulation prescribe the time, manner and form for filing claims under this section or may require claims to be allowed by an ancillary receiver or the domestic liquidator or receiver.

(b) The Commissioner may not use funds obtained under subsection (1) to pay claims by participating providers for services rendered to subscribers or enrollees prior to insolvency of the health maintenance organization.

(3)(a) A receiver or liquidator of an insolvent health maintenance organization shall allow a claim in the proceeding in an amount equal to administrative and uncovered expenditures paid under this section.

(b) Any person receiving benefits under this section for uncovered expenditures is deemed to have assigned the rights under the covered health care plan certificates to the commissioner to the extent of the benefits received. The commissioner may require an assignment to it of such rights by any payee, enrollee, or beneficiary as a condition precedent to the receipt of any rights or benefits conferred by this section upon such person. The commissioner is subrogated to these rights against the assets of any insolvent health maintenance organization held by a receiver or liquidator of another jurisdiction.

(c) The assignment or subrogation rights of the commissioner and allowed claim under this subsection have the same priority against the assets of the insolvent health maintenance organization as those possessed by the person entitled to receive benefits under this section or for similar expenses in the receivership or liquidation.

(4) When assessed funds are unused following the completion of the liquidation of a health maintenance organization, the commissioner will distribute on a pro rata basis any amounts received under subsection (1) which are not de minimis to the health maintenance organizations which have been assessed under this section.

(5) The aggregate coverage of uncovered expenditures under this section shall not exceed Three Hundred Thousand Dollars ($300,000.00) with respect to any one (1) individual. Continuation of coverage shall not continue for more than the lesser of one (1) year after the health maintenance organization

coverage is terminated by insolvency or the remaining term of the contract. The commissioner may provide continuation of coverage on any reasonable basis; including, but not limited to, continuation of the health maintenance organization contract or substitution of indemnity coverage in a form determined by the commissioner.

(6) The commissioner may waive an assessment of any health maintenance organization if it would be or is impaired or placed in financially hazardous condition. A health maintenance organization which fails to pay an assessment within thirty (30) days after notice is subject to a civil forfeiture of not more than One Thousand Dollars ($1,000.00) per day or suspension or revocation of its certificate of authority or both fine and suspension. Any action taken by the commissioner in enforcing the provisions of this section may be appealed by the health maintenance organization in accordance with the Chancery Court of the First Judicial District of Hinds County, Mississippi.

HISTORY: Laws, 1995, ch. 613, § 32, eff from and after July 1, 1995.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 15, 28.

CJS.
44 C.J.S., Insurance §§ 189 et seq.

§ 83-41-365. Contracting authority of commissioner.

The commissioner may contract with the necessary personnel to carry out the duties and responsibilities created by this article and make assessments for the expenses incurred in carrying out the duties and responsibilities of this article.

HISTORY: Laws, 1995, ch. 613, § 33, eff from and after July 1, 1995.

RESEARCH REFERENCES

Am. Jur.
40 Am. Jur. 2d, Hospitals and Asylums § 5.

ARTICLE 9.

PATIENT PROTECTION ACT OF 1995.

Sec.
83-41-401. Short title.
83-41-403. Definitions.
83-41-405. Requirement of certification of managed care plans offered or provided to persons residing in Mississippi; termination of plans.
83-41-407. Fees.
83-41-409. Conditions for certification or recertification.
83-41-411. Compliance with article by health maintenance organizations.
83-41-413. Regulations.

Sec.
83-41-415. Applicability of Articles 7 and 9 to Division of Medicaid in Office of Governor.
83-41-417. Geographic areas served; opportunity to apply for participation.

§ 83-41-401. Short title.

This article shall be known and may be cited as the "Patient Protection Act of 1995."

HISTORY: Laws, 1995, ch. 613, § 36, eff from and after July 1, 1995.

§ 83-41-403. Definitions.

As used in this article:

(a) "Department" means the Mississippi Department of Insurance.

(b) "Managed care plan" means a plan operated by a managed care entity as described in subparagraph (c) that provides for the financing and delivery of health care services to persons enrolled in such plan through:

(i) Arrangements with selected providers to furnish health care services;

(ii) Explicit standards for the selection of participating providers;

(iii) Organizational arrangements for ongoing quality assurance, utilization review programs and dispute resolution; and

(iv) Financial incentives for persons enrolled in the plan to use the participating providers, products and procedures provided for by the plan.

(c) "Managed care entity" includes a licensed insurance company, hospital or medical service plan, health maintenance organization (HMO), an employer or employee organization, or a managed care contractor as described in paragraph (d) of this section that operates a managed care plan.

(d) "Managed care contractor" means a person or corporation that:

(i) Establishes, operates or maintains a network of participating providers;

(ii) Conducts or arranges for utilization review activities; and

(iii) Contracts with an insurance company, a hospital or medical service plan, an employer or employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

(e) "Participating provider" means a physician, hospital, pharmacy, pharmacist, dentist, nurse, chiropractor, optometrist, or other provider of health care services licensed or certified by the state, that has entered into an agreement with a managed care entity to provide services, products or supplies to a patient enrolled in a managed care plan.

HISTORY: Laws, 1995, ch. 613, § 37, eff from and after July 1, 1995.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "paragraph (d) of this section" for "subparagraph (d)" near the end of (c). The Joint Committee ratified the correction at its August 10, 2022, meeting.

Cross References — Powers of regional commissions created for the purpose of establishing mental illness and mental retardation facilities and services, see § 41-19-31.

Duty of managed care entity to provide opportunities for participation by health care providers in geographic area, see § 83-41-417.

RESEARCH REFERENCES

ALR.

Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

§ 83-41-405. Requirement of certification of managed care plans offered or provided to persons residing in Mississippi; termination of plans.

The department shall establish a process for the certification of managed care plans offered or provided to persons residing in Mississippi. No such plan shall be offered or provided to persons residing in this state unless it has been certified by the department. Any managed care plan certified by the department must be recertified annually, and the department shall establish procedures to ensure the continued compliance with the requirements of Section 83-41-409 through the recertification process. The department shall terminate the certificate of any managed care plan if such plan no longer meets the applicable requirements for certification. The department shall provide any such plan with an opportunity for a hearing on the proposed termination.

HISTORY: Laws, 1995, ch. 613, § 38, eff from and after July 1, 1995.

§ 83-41-407. Fees.

The department shall establish a fee to cover the costs of issuing and renewing the certifications authorized by this article and the fees shall be used solely for the administration of this article.

HISTORY: Laws, 1995, ch. 613, § 39, eff from and after July 1, 1995.

§ 83-41-409. Conditions for certification or recertification.

In order to be certified and recertified under this article, a managed care plan shall:

(a) Provide enrollees or other applicants with written information on the terms and conditions of coverage in easily understandable language including, but not limited to, information on the following:

(i) Coverage provisions, benefits, limitations, exclusions and restrictions on the use of any providers of care;

(ii) Summary of utilization review and quality assurance policies; and

(iii) Enrollee financial responsibility for copayments, deductibles and payments for out-of-plan services or supplies;

(b) Demonstrate that its provider network has providers of sufficient number throughout the service area to assure reasonable access to care with minimum inconvenience by plan enrollees;

(c) File a summary of the plan credentialing criteria and process and policies with the State Department of Insurance to be available upon request;

(d) Provide a participating provider with a copy of his/her individual profile if economic or practice profiles, or both, are used in the credentialing process upon request;

(e) When any provider application for participation is denied or contract is terminated, the reasons for denial or termination shall be reviewed by the managed care plan upon the request of the provider; and

(f) Establish procedures to ensure that all applicable state and federal laws designed to protect the confidentiality of medical records are followed.

HISTORY: Laws, 1995, ch. 613, § 40, eff from and after July 1, 1995.

§ 83-41-411. Compliance with article by health maintenance organizations.

Health maintenance organizations must comply with the certification requirements in this article in addition to such other laws as might relate thereto.

HISTORY: Laws, 1995, ch. 613, § 41, eff from and after July 1, 1995.

Cross References — Health maintenance organizations generally, see §§ 83-41-301 et seq.

§ 83-41-413. Regulations.

The department shall adopt regulations to implement the provisions of this article and may obtain any information from managed care plans that is necessary to determine if such plan should be certified or recertified.

HISTORY: Laws, 1995, ch. 613, § 42, eff from and after July 1, 1995.

§ 83-41-415. Applicability of Articles 7 and 9 to Division of Medicaid in Office of Governor.

Articles 7 and 9 do not apply to the Division of Medicaid in the Office of the Governor.

HISTORY: Laws, 1995, ch. 613, § 43, eff from and after July 1, 1995.

Cross References — Articles 7 and 9 of this chapter, see §§ 83-41-301 et seq. and 83-41-401 et seq.

§ 83-41-417. Geographic areas served; opportunity to apply for participation.

A health maintenance organization as defined in Section 83-41-303, and a managed care entity as defined in Section 83-41-403, shall establish procedures to give interested health care providers located in the geographic area served an opportunity to apply for participation.

HISTORY: Laws, 1995, ch. 613, § 44, eff from and after July 1, 1995.

CHAPTER 43.

NONPROFIT DENTAL SERVICE CORPORATIONS

Sec.

83-43-1. Citation.
83-43-3. Definitions.
83-43-5. Unauthorized nonprofit dental service forbidden.
83-43-7. Regulation and supervision.
83-43-9. License.
83-43-11. Scope of service.
83-43-13. Rights of dentists.
83-43-15. Corporate rights and powers.
83-43-17. Limitation of subscriber's contract.
83-43-19. Officers may subscribe for service.
83-43-21. Financial report.
83-43-23. Investment.
83-43-25. Dental service report.
83-43-27. Agent's performance of functions.
83-43-29. Penalties.
83-43-31. Enforcement.
83-43-33. Partial tax exemption.
83-43-35. Dissolution or liquidation.
83-43-37. Construction.

§ 83-43-1. Citation.

This chapter shall be known and may be cited as the "Nonprofit Dental Service Corporation Law."

HISTORY: Codes, 1942, § 8775-01; Laws, 1962, ch. 234, § 1, eff from and after passage (approved May 7, 1962).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 15, 66.

§ 83-43-3. Definitions.

As used in this chapter:

(a) "Dentists" means persons holding a license to practice dentistry under Sections 73-9-1 through 73-9-65, Mississippi Code of 1972.

(b) "Dental services" include the general and usual services rendered and care administered by dentists as defined in Sections 73-9-1 through 73-9-65, Mississippi Code of 1972.

(c) "Nonprofit dental service corporation" includes a corporation organized and operated under the provisions of Section 79-11-101, Mississippi Code of 1972, and all other applicable statutes governing nonprofit corporations.

(d) "State Board of Health" means Mississippi State Board of Health.

(e) "Court" means the chancery court of the county where the principal office of the nonprofit dental corporation is or is to be located.

HISTORY: Codes, 1942, § 8775-02; Laws, 1962, ch. 234, § 2; Laws, 1997, ch. 410, § 22, eff from and after July 1, 1997.

§ 83-43-5. Unauthorized nonprofit dental service forbidden.

It shall be unlawful for any person, copartnership, association, common law trust, or corporation, except when especially organized and authorized under the provisions of the nonprofit corporation statutes for the purpose, to establish, maintain, or operate a nonprofit dental service plan whereby dental services may be provided to persons or groups of persons for prepayment, periodical, or lump sum payments, but this shall not be construed as preventing a person, copartnership, association, common law trust, or corporation from furnishing dental services among its or his employees when the employee is not charged for such service. Nor shall any provision in this chapter be construed to apply to beneficial, benevolent, fraternal, benefit societies having a lodge system and representative form of government.

HISTORY: Codes, 1942, § 8775-03; Laws, 1962, ch. 234, § 3; Laws, 1997, ch. 307, § 6, eff from and after July 1, 1997.

Cross References — Fraternal benefit societies, see §§ 83-29-1 et seq.

§ 83-43-7. Regulation and supervision.

A nonprofit dental service corporation shall be subject to regulation and supervision by the state board of health, state auditor, and the attorney general as provided by this chapter. It shall not be subject to the laws of this state now in force, except as herein specifically stated, relating to insurance and corporations engaged in the business of insurance, nor to any law hereafter enacted relating to insurance and corporations engaged in the business of insurance, unless such law specifically and in exact terms applies to such nonprofit dental service corporation.

HISTORY: Codes, 1942, § 8775-04; Laws, 1962, ch. 234, § 4, eff from and after passage (approved May 7, 1962).

Editor's Notes — Section 7-7-2, as added by Laws, 1984, chapter 488, § 90, and amended by Laws, 1985, chapter 455, § 14, Laws, 1986, chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor," and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws, 1989, chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws, 1989, ch. 544, § 17, effective July 1, 1989, and codified as

§ 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration."

Cross References — Qualifications of attorney general, see § 7-5-1.

Qualifications of dentist member of state board of health, see § 41-3-1.

Regulation and supervision of insurance corporations, see §§ 83-1-1 et seq.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance § 67.

§ 83-43-9. License.

A nonprofit dental service corporation may not enter into dental service contracts under the provisions hereof until it has procured a formal certificate or license from the state board of health authorizing it to do so. Application for such certificate of authority or license shall be made on such forms as the state board of health may prescribe and shall be accompanied by the following documents: (a) certified copy of charter of incorporation, (b) certified copy of current bylaws, (c) an affidavit of the secretary of the Mississippi State Board of Dental Examiners setting forth that he has satisfactory evidence that at least twenty percent (20%) of the licensed dentists residing and actively practicing in the state have agreed to render professional service to subscribers under such plan, (d) a certificate from the Mississippi State Board of Dental Examiners approving the licensing of such dental service corporation, and (e) such other information as the state board of health may require concerning the public interest, welfare, and necessity of licensing such dental service corporation. The state board of health shall issue a certificate of authority or license upon payment of a fee of Twenty-five Dollars ($25.00) and upon being satisfied that the public interest, welfare, and necessity will be served by so doing. All licenses issued to every such corporation shall expire on the last day of the next succeeding March, but shall be subject to annual renewal under the foregoing terms and conditions.

HISTORY: Codes, 1942, § 8775-05; Laws, 1962, ch. 234, § 5, eff from and after passage (approved May 7, 1962).

Cross References — General duties of state board of health, see § 41-3-15.

Powers and duties of state board of dental examiners, see § 73-9-13.

§ 83-43-11. Scope of service.

(1) A nonprofit dental service corporation may, by its articles of incorporation, its bylaws, or resolutions of its board of directors, limit the dental services that it will provide for its subscribers and may divide such dental services as it elects to provide into classes or kinds; and it may enter into contracts with its subscribers or groups of subscribers to secure dental services of any kind or class so named and delimited.

(2) A nonprofit dental service corporation shall not provide dental services for its subscribers otherwise than through licensed dentists.

(3) A nonprofit dental service corporation shall provide dental services only to persons domiciled within the state; but if a subscriber regularly domiciled within the state and entitled to dental services, or any of his dependents so entitled, necessarily employs dental services within the meaning of this chapter while absent from the state, a dental service corporation to which he is a subscriber may, in its discretion and if satisfied as to the necessity for such services and satisfied that it was such as the subscriber would have been entitled to under similar circumstances in this state, pay to the dentist or dentists who rendered the services such fees and charges as would have been payable if the services had been rendered in this state. A nonprofit dental service corporation organized under the laws of this state and operating near its boundaries may, with the consent of the proper officers of and as authorized by the law of the adjacent state, provide dental services therein, but all operations of any such corporation, whether within or without this state, shall remain at all times subject to the provisions of this chapter.

(4) All dental services provided by or on behalf of a nonprofit dental service corporation shall be in accordance with the best dental practice in the community at the time, but the corporation providing such services shall not be liable for injuries resulting from negligence, misfeasance, malfeasance, nonfeasance, or malpractice on the part of any officer or employee or on the part of any dentist in the course of rendering dental services to subscribers; and the corporation may so provide in its contracts with subscribers.

HISTORY: Codes, 1942, § 8775-05; Laws, 1962, ch. 234, § 5, eff from and after passage (approved May 7, 1962).

Cross References — Enforcement of Dental Practice Law, see § 73-9-17.

RESEARCH REFERENCES

ALR.

Liability for dental malpractice in provision or fitting of dentures. 77 A.L.R.4th 222.

§ 83-43-13. Rights of dentists.

(1) Every dentist practicing within the area covered by any nonprofit dental service corporation shall have the right, on complying with such regulations as the corporation may make and with the approval of the state board of health, to register with such corporation for general or special dental service, as the case may be, within that area. Any nonprofit dental service corporation may, with the approval of the state board of health and the state board of dental examiners, remove from its register the name of any dentist, after due notice and hearing, for cause satisfactory to the corporation.

(2) A nonprofit dental service corporation shall impose no restrictions on the dentists who administer to its subscribers as to methods of diagnosis or treatment. The relation between a subscriber or any of his dependents and the dentist shall be identical with the relation that ordinarily exists in the community between such doctor and his patient. No person shall be permitted

to interfere with a patient's choice or selection of his dentist after that choice or selection has been made by an adult of sound mind; and any dentist shall have freedom of choice in registering for services with the corporation and may refuse to accept individual cases, so long as such refusal does not have the effect of an abrogation or revocation of any agreement existing between him and the corporation prior to its expiration.

(3) All matters, disputes, or controversies relating to the dental services rendered by the dentists or any questions involving professional ethics shall be considered, acted upon, disposed of, and determined by dentists, as selected in a manner prescribed in the bylaws of the nonprofit dental service corporations.

HISTORY: Codes, 1942, § 8775-06; Laws, 1962, ch. 234, § 6, eff from and after passage (approved May 7, 1962).

Cross References — Duty of state board of health to supervise health interests of people, see § 41-3-15.

§ 83-43-15. Corporate rights and powers.

In addition to the rights and powers that may be exercised by nonprofit corporations under Sections 79-11-1 through 79-11-33, Mississippi Code of 1972, nonprofit dental service corporations created and organized under the provisions of this chapter shall be authorized to exercise the following rights and powers, to wit:

(a) To encourage, foster, and finance professional and scientific study and research in the general field of dentistry; to make studies and conduct investigations designed to develop information, statistics, and knowledge pertaining to all aspects of dental service payment plans, and to assist in the education and enlightenment of the public concerning the needs and advantages of adequate dental treatment and care.

(b) To enter into and carry out contracts for furnishing dental services to individuals and groups of individuals, provided, however, that no contract by or on behalf of any nonprofit dental service corporation shall provide for the payment of any cash or other material benefit by that corporation to a subscriber on account of illness or injury nor be in any way related to the payment of any such benefit by any other agency.

(c) To procure and enter into contracts with dentists, hygienists, laboratory technicians, oral surgeons, hospitals, pharmacies, and other persons, firms, and corporations to carry out any of the objects and purposes of this corporation.

(d) To operate an administrative office and dental clinics, laboratories, and other facilities appropriate or convenient for the rendition of dental services, and to employ personnel for the conduct thereof.

(e) To establish and maintain funds secured through payments to be used to defray the cost of dental services, to predicate payments into such funds on actuarial prediction and experience, and to issue contracts entitling the holder or subscriber thereto to dental services as enumerated therein and subject to the terms and provisions as may be therein provided.

(f) To establish eligibility requirements for individuals and groups of individuals seeking to subscribe to its dental service plans, and to determine the eligibility thereunder of persons subscribing to its contracts. Any and all requisites thus fixed and all contracts for dental services offered by the corporation shall be subject to the approval of the state board of health.

(g) To accept gifts, donations, contributions and property by bequest or devise, or in trust, and to use and apply the same in furtherance of the objects and purposes of such corporation.

HISTORY: Codes, 1942, § 8775-07; Laws, 1962, ch. 234, § 7, eff from and after passage (approved May 7, 1962).

Editor's Notes — Sections 79-11-1 through 79-11-29, referred to in the opening paragraph of this section, were repealed by Laws of 1987, ch. 485, § 153, effective January 1, 1988. For text of the Mississippi Nonprofit Corporation Act, see §§ 79-11-101 et seq.

Cross References — General duties of state board of health, see § 41-3-15.

§ 83-43-17. Limitation of subscriber's contract.

A nonprofit dental service corporation may, as a condition precedent to entering into a contract with an applicant or group of applicants for dental service:

(a) Require a physical examination of the applicant and of each of his dependents, if any, and proof of his or their substantial freedom from any disease or condition requiring immediate dental service or likely to require it within the next six (6) months before a contract becomes effective, or

(b) require a waiting period after a contract is entered into and before the subscriber is entitled to dental service, or

(c) require that the subscriber or someone on his behalf shall pay the stated fee or fees for dental services in the care of any given illness or injury or other condition requiring dental service before becoming entitled to treatment under the terms of the contract.

(d) Provided, however, that nothing in this chapter shall be construed to require any individual, or group of individuals, to become a subscriber or subscribers to any such plan against his or their own free will and accord.

HISTORY: Codes, 1942, § 8775-08; Laws, 1962, ch. 234, § 8, eff from and after passage (approved May 7, 1962).

§ 83-43-19. Officers may subscribe for service.

Every department, commission, officer, or other agency of the state, or of any political subdivision thereof, who is authorized or charged by law with the duty of providing dental services within the meaning of this chapter for persons unable to provide it entirely at their own expense, or to procure it through persons to whose support and assistance they are by law entitled, is hereby empowered in the exercise of his authority to provide such service if, in his judgment, it is in the public interest so to do, through a subscription or subscriptions paid for from any lawfully available public funds with any nonprofit dental service corporation on behalf of any person or persons entitled to such relief. Provided, however, that the extent of public funds contributed to such services, other than those funds disbursed by the state welfare program, shall not exceed the limitations authorized by Section 25-15-103, Mississippi Code of 1972.

HISTORY: Codes, 1942, § 8775-09; Laws, 1962, ch. 234, § 9, eff from and after passage (approved May 7, 1962).

Cross References — Group insurance for public employees, see §§ 25-15-101 et seq.

§ 83-43-21. Financial report.

Every nonprofit dental service corporation shall, on or before the first day of March of every year, file with the state auditor of public accounts a statement verified by at least two (2) of the principal officers of the corporation, summarizing its financial activities during the calendar year immediately preceding and showing its financial condition at the close of business on the thirty-first day of December of that year. Such statement shall be in such form and shall contain such matter as the state auditor prescribes. The financial affairs and status of every such corporation may be examined by the attorney general of the state not less frequently than once in every three (3) years and, for that purpose, the attorney general and his assistants shall be entitled to the aid and cooperation of the officers and employees of the corporation and shall have convenient access to all books, records, papers, and documents that relate to the business of the corporation. They shall have authority to examine the officers, agents, employees, and subscribers for the dental services of the corporation, all cooperating dentists registered with the corporation, and all other persons having or having had substantial part in the work of the corporation in relation to its affairs, transactions, and financial condition. Such examinations shall be made at such times and with such frequency as the attorney general may determine. He or the state auditor may, at any time without making such examination, call on any such corporation for a written report, authenticated by at least two (2) of its principal officers, concerning the financial affairs and status of the corporation.

HISTORY: Codes, 1942, § 8775-10; Laws, 1962, ch. 234, § 10, eff from and after passage (approved May 7, 1962).

Editor's Notes — Section 7-7-2, as added by Laws, 1984, chapter 488, § 90, and amended by Laws, 1985, chapter 455, § 14, Laws, 1986, chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor," and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws, 1989, chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws, 1989, ch. 544, § 17, effective July 1, 1989, and codified as § 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration."

Cross References — Audit of annual financial statements of insurers, see §§ 83-5-101 et seq.

§ 83-43-23. Investment.

Surplus funds, if any, of any such corporation may be invested and, if invested, shall be in compliance with the requirements of law for the investment of the surplus of life insurance companies.

HISTORY: Codes, 1942, § 8775-11; Laws, 1962, ch. 234, § 11, eff from and after passage (approved May 7, 1962).

Cross References — Authorized investments for funds of domestic insurance companies, see §§ 83-19-51, 83-19-53.

§ 83-43-25. Dental service report.

Every nonprofit dental service corporation shall, on or before the first day of March of every year, file with the state board of health a report of its activities other than its financial activities during the calendar year immediately preceding. Every such report shall be authenticated by at least two (2) of the principal officers of the corporation and shall be in such form and contain such matter as the state board of health prescribes. The state board of health is hereby authorized to inquire into the activities of the nonprofit dental service corporations and to determine whether the corporation is providing adequate dental services to its subscribers in accordance with the best dental practice in the community. The secretary of the state board of health and his agents shall be entitled to the aid and cooperation of the officers and employees of the corporation and shall have convenient access to all books, records, papers, and documents that relate to the business of the corporation. They shall have authority to examine the officers, agents, employees and subscribers for the service of the corporation, all dentists registered with the corporation, and all other persons having or having had substantial part in the work of the corporation in relation to the affairs, transactions, and conditions of the corporation other than financial. Examinations may be made at such times and with such frequency as the secretary of the state board of health may determine. The secretary of the state board of health may, at any time without making any such examination, call on any such corporation for a written report, authenticated by at least two (2) of its principal officers, concerning the affairs of the corporation other than its financial affairs. In the event the secretary of the state board of health finds that the nonprofit dental service corporation does not provide adequate dental services to its subscribers in accordance with the best dental practice in the community, the said secretary may notify the corporation of his findings and order the corporation, in specific terms, to extend or improve the dental services furnished by the corporation.

Within thirty (30) days after receipt of such notice from the secretary, the corporation may petition the court to show cause why the action of the secretary of the state board of health should not be set aside or modified. The court is given jurisdiction and authority to entertain and determine any such proceeding and controversy.

HISTORY: Codes, 1942, § 8775-12; Laws, 1962, ch. 234, § 12, eff from and after passage (approved May 7, 1962).

Cross References — Composition and duties of state board of health, see §§ 41-3-1.1 et seq.

§ 83-43-27. Agent's performance of functions.

Any nonprofit dental service corporation may select any person, copartnership, association, common law trust, or corporation to act as its agent in the performance of any of its functions. Any such delegation of authority shall not operate to release the nonprofit dental service corporation from any of its duties and responsibilities required by this chapter.

HISTORY: Codes, 1942, § 8775-13; Laws, 1962, ch. 234, § 13, eff from and after passage (approved May 7, 1962).

§ 83-43-29. Penalties.

Any dentist and any other person, copartnership, association, common law trust, or corporation who violates any provision of this chapter or of any order of the state board of health, of the attorney general, or of the state auditor made pursuant thereto, or that either prevents the state board of health or the state officers to discharge any duties imposed upon them by this chapter, or fraudulently procures or attempts to procure any benefits under this chapter, or that willfully makes any false statement in any proceeding or report under the provisions of this chapter, shall be guilty of a misdemeanor and, on conviction thereof, shall be sentenced to pay a fine of not more than Five Hundred Dollars ($500.00), or to be imprisoned for not more than six (6) months, or both such fine and imprisonment. Any act or default by any corporation, association, or common law trust in violation of any provisions of the chapter, or of any order of the department made pursuant thereto shall be deemed to be the act or default of its officers or directors who participated in authorizing or effecting such act or default, or who knowingly permitted it.

HISTORY: Codes, 1942, § 8775-14; Laws, 1962, ch. 234, § 14, eff from and after passage (approved May 7, 1962).

Editor's Notes — Section 7-7-2, as added by Laws, 1984, chapter 488, § 90, and amended by Laws, 1985, chapter 455, § 14, Laws, 1986, chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor," and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws, 1989, chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws, 1989, ch. 544, § 17, effective July 1, 1989, and codified as § 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration."

Cross References — Authority of state officers and state board of health to regulate and supervise nonprofit dental service corporations, see § 83-43-7.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

§ 83-43-31. Enforcement.

When necessary to effect the purposes of this chapter, in addition to all other remedies in law or equity, the attorney general or state auditor, the secretary of the state board of health, or either of them, may be and are hereby authorized to petition the court for a mandamus or injunction to prevent any violation of the provisions of this chapter, or the continuance of any such violation, or to enforce compliance herewith. The court is hereby vested with authority to entertain jurisdiction on any such petition to determine the cause and to issue such process as may be necessary to accomplish the purposes of this chapter.

HISTORY: Codes, 1942, § 8775-15; Laws, 1962, ch. 234, § 15, eff from and after passage (approved May 7, 1962).

Editor's Notes — Section 7-7-2, as added by Laws, 1984, chapter 488, § 90, and amended by Laws, 1985, chapter 455, § 14, Laws, 1986, chapter 499, § 1, provided, at subsection (2) therein, that the words "state auditor of public accounts," "state auditor," and "auditor" appearing in the laws of the state in connection with the performance of auditor's functions transferred to the state fiscal management board, shall be the state fiscal management board, and, more particularly, such words or terms shall mean the state fiscal management board whenever they appear. Thereafter, Laws, 1989, chapter 532, § 2, amended § 7-7-2 to provide that the words "State Auditor of Public Accounts," "State Auditor" and "Auditor" appearing in the laws of this state in connection with the performance of Auditor's functions shall mean the State Fiscal Officer, and, more particularly, such words or terms shall mean the State Fiscal Officer whenever they appear. Subsequently, Laws, 1989, ch. 544, § 17, effective July 1, 1989, and codified as § 27-104-6, provides that wherever the term "State Fiscal Officer" appears in any law it shall mean "Executive Director of the Department of Finance and Administration."

Cross References — Authority of state officers and state board of health to enforce compliance with nonprofit dental service corporation law, see § 83-43-7.

§ 83-43-33. Partial tax exemption.

Every corporation organized pursuant to, or subject to, the provisions of this chapter is hereby declared to be a charitable and benevolent institution, and its funds and property shall be exempt from taxation, except, however, that such corporation shall not be exempt from ad valorem taxes upon real estate and motor vehicles owned by it.

HISTORY: Codes, 1942, § 8775-16; Laws, 1962, ch. 234, § 16; Laws, 1978, ch. 441, § 9, eff from and after July 1, 1978.

Cross References — Exemption from taxation of property of charitable and benevolent institutions, see §§ 27-31-1 et seq.

§ 83-43-35. Dissolution or liquidation.

Any dissolution or liquidation of a corporation subject to the provisions of this chapter shall be conducted under the supervision of the attorney general and the state board of health. All assets of the corporation shall, upon dissolution or liquidation and after adequate provision is made for the discharge of all debts and obligations of the corporation, be transferred and distributed to the state board of health to be expended by it in providing dental care and treatment for indigent persons.

HISTORY: Codes, 1942, § 8775-17; Laws, 1962, ch. 234, § 17, eff from and after passage (approved May 7, 1962).

§ 83-43-37. Construction.

It is hereby declared to be the purpose and intent of this chapter and the policy of the legislature to authorize qualified dentists engaged in private practice to provide adequate dental services for residents of this state through a sound prepayment plan with the cooperation of the Mississippi Dental Association and state board of dental examiners, with appropriate state supervision to insure that subscribers thereto will continue to receive the highest type professional dental care with their free and voluntary choice of dentists, and at the same time it is the purpose and intent of this chapter and the policy of the legislature to maintain the standing and promote the progress of the science and art of dental surgery in this state. The courts of this state are hereby directed to construe this chapter liberally in order to accomplish those ends.

HISTORY: Codes, 1942, § 8775-18; Laws, 1962, ch. 234, § 18, eff from and after passage (approved May 7, 1962).

CHAPTER 45.

NONPROFIT, COMMUNITY SERVICE BLOOD SUPPLY PLANS

Sec.

83-45-1. Operation of plan as constituting the writing of insurance.
83-45-3. Requirement for licensing.
83-45-5. Approval of articles; issuance of license.
83-45-7. Examinations; annual reports.
83-45-9. Solicitation of membership.
83-45-11. Approval of general administrative expenses.
83-45-13. Dissolution.

§ 83-45-1. Operation of plan as constituting the writing of insurance.

The operation of a blood supply plan, on a nonprofit, community service basis, for the purpose of promoting and encouraging the donation of human blood for medicinal and transfusion uses may or may not constitute the writing of insurance. However, an agreement between such a nonprofit organization promoting and encouraging such blood donation and one or more of its donors by which the nonprofit organization agrees to pay the cost, or a part thereof, of supplying transfusion blood to such donor or designated members of his family shall constitute a contract of insurance.

This form of insurance will be governed only by this chapter.

HISTORY: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).

§ 83-45-3. Requirement for licensing.

Requirement for licensing shall be as follows:

(a) A deposit with any depository approved by the state for the benefit of policyholders/members in the amount of One Dollar ($1.00) for each policyholder currently insured to guarantee perpetuation of the organization until all membership contracts are terminated.

(b) A deposit in a like amount to a catastrophe fund, but this deposit shall be made on the first renewal of each contract.

HISTORY: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).

§ 83-45-5. Approval of articles; issuance of license.

Such company or organization shall have its articles of incorporation or articles of organization approved by the attorney general and the commissioner of insurance and subsequently filed in the office of secretary of state. Filing fee for such articles shall be Five Dollars ($5.00). A license shall be issued by the commissioner of insurance to expire the next ensuing December 31, and the fee for such license for one (1) year shall be Ten Dollars ($10.00) per year or any part thereof.

HISTORY: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).

§ 83-45-7. Examinations; annual reports.

Any such organization shall be exempt from regular examination by the insurance department, but shall be examined when deemed advisable by the commissioner of insurance.

Annual reports shall be filed with the insurance department in the manner and form prescribed by the commissioner of insurance.

Upon submission of annual statements, same shall be reviewed by the commissioner of insurance and the commissioner may issue such orders as necessary to stabilize operation of the company or organization.

HISTORY: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).

§ 83-45-9. Solicitation of membership.

Solicitation of membership may be made through direct advertising, group solicitation, by officers or by individuals without licensing of solicitors, provided this is the only insurance which is offered or solicited by the company or organization.

HISTORY: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).

§ 83-45-11. Approval of general administrative expenses.

General administrative expenses shall be submitted to and approved by the department of insurance.

HISTORY: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).

§ 83-45-13. Dissolution.

Upon dissolution of such organization, the department of insurance shall be satisfied that all policyholders/members' claims have been paid before approving the release of deposits.

In event of dissolution and surrender of articles of association and/or charter, any surplus after reimbursement of organizational funds and any other contribution to surplus shall be prorated among such organizing contributors at the highest rate of interest possible, not to exceed ten percent (10%). When and if surplus exists in excess of reimbursements hereinabove set out, such amount shall escheat to the general fund of the State of Mississippi upon dissolution of the company or organization.

HISTORY: Codes, 1942, § 5633; Laws, 1972, ch. 432, § 1, eff from and after passage (approved May 1, 1972).

CHAPTER 47.

NONPROFIT MEDICAL LIABILITY INSURANCE CORPORATIONS

Sec.

83-47-1. Declaration of purpose.

83-47-3. Formation of corporation; contents and approval of articles of incorporation.

83-47-5. Election of board of directors; membership in corporation; termination of membership; adoption of bylaws.

83-47-7. Establishing minimum capital and reserve; enforcement by injunction or mandamus.

83-47-9. Dues, fees and assessments; separate classes and groupings for fixing assessments of members; premium taxes.

83-47-11. Liability of members for debts of corporation; exemption of private property from execution.

83-47-13. Annual statement.

83-47-15. Investigation of affairs of corporation; access to books and documents; summoning and examining witnesses under oath.

83-47-17. Dissolution or liquidation of corporation.

83-47-19. Declaration of charitable status; exemption from taxation.

83-47-21. Conversion of nonprofit and nonshare corporations into nonprofit medical liability insurance corporations.

83-47-23. Nonprofit medical liability insurance corporations not covered by insurance guaranty association law.

83-47-25. Procedure for converting nonprofit medical liability insurance corporation to stock insurance corporation.

§ 83-47-1. Declaration of purpose.

The public health and welfare requires the adoption of this chapter providing for the organization and operation of nonprofit medical liability insurance corporations.

HISTORY: Laws, 1977, ch. 491, § 1, eff from and after passage (approved April 15, 1977).

RESEARCH REFERENCES

Law Reviews.

Checking Up On the Medical Malpractice Liability Insurance Crisis in Mississippi: Are Additional Tort Reforms the Cure?, 73 Miss. L.J. 1001 (2004).

Hurricane Katrina Special Edition: Revamping the Wind Pool, 77 Miss. L.J. 795, Spring, 2008.

Practice References.

Business Law Monographs, Volume IN2—Casualty and Liability Insurance (Matthew Bender).

§ 83-47-3. Formation of corporation; contents and approval of articles of incorporation.

Any seven (7) or more physicians licensed to practice in Mississippi who are residents of this state, may form a nonprofit corporation under this chapter for the purpose of providing medical, professional, general and other liability insurance to health care providers, health care facilities and managed care organizations in Mississippi and any other state or jurisdiction. The term "health care provider," when used in this chapter, shall mean a physician, dentist, pharmacist, osteopath, psychologist, podiatrist, optometrist, chiropractor, nurse, medical technician or other health care provider licensed by the State of Mississippi or any other state or jurisdiction. The term "health care facility," when used in this chapter, shall mean a medical clinic, nursing home, outpatient surgical center, laboratory, pharmacy, dialysis clinic, hospital or other health care facility licensed, if necessary, by the State of Mississippi or any other state or jurisdiction. The term "managed care organization," when used in this chapter, shall mean a health maintenance organization (HMO), individual practice association (IPA), preferred provider organization (PPO), competitive medical plan (CMP), exclusive provider organization (EPO), integrated delivery system (IDS), independent physician/provider organization (IPO), management service organization (MSO), physician hospital/provider organization (PHO) and any other type of managed care organization. Members of the corporation shall consist of only individuals under contracts which entitle such individuals to medical liability insurance. Health care facilities and managed care organizations need not be owned by or comprised of members of the corporation in order to be insured by the corporation. All such corporations shall be governed by this chapter and shall be exempt from all other provisions of the insurance laws of this state, unless otherwise specifically provided herein. Such a corporation may be formed under this chapter in the following manner:

(a) The proposed incorporators shall subscribe articles of incorporation in which shall be stated:

(i) The proposed corporate name of the corporation, which shall not so closely resemble the name of any other corporation already transacting business in this state as to mislead the public or lead to confusion;

(ii) The domicile of the proposed corporation;

(iii) The names and post office addresses of the incorporators;

(iv) The fact that application for charter is being made under this chapter and the corporation proposed to operate under and subject to the provisions of this chapter;

(v) The purposes of the corporation.

(b) Such articles of incorporation shall be filed with the Commissioner of Insurance, who shall refer the same to the Attorney General for his opinion as to whether the same meet the requirements of this chapter and are not otherwise violative of the Constitution or laws of this state or of the United States. The Attorney General shall examine the same and endorse his opinion thereon and return the same to the Commissioner of Insurance for approval. The Commissioner of Insurance shall (if the same be approved by the Attorney General) thereupon endorse his certificate of approval upon such articles of incorporation, record the same in his office, and refer the same to the office of the Secretary of State to be there recorded, whereupon said corporation shall become and be considered an existing entity. The articles of incorporation as thus approved and recorded shall be and constitute the charter of incorporation of such corporation. It shall not be necessary that such charter be published, nor shall it be necessary that it be recorded in the office of the chancery clerk.

HISTORY: Laws, 1977, ch. 491, § 2; Laws, 1995, ch. 372, § 1, eff from and after passage (approved March 15, 1995).

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in the third sentence of the introductory paragraph. The words "integrated delivery system (EDS)" were changed to "integrated delivery system (IDS)." The Joint Committee ratified the correction at its May 20, 1998, meeting.

RESEARCH REFERENCES

ALR.
Liability of health maintenance organizations (HMOs) for negligence of member physicians. 51 A.L.R.5th 271.

Am. Jur.
44A Am. Jur. 2d, Insurance § 1419.

CJS.
45 C.J.S., Insurance § 1206.

§ 83-47-5. Election of board of directors; membership in corporation; termination of membership; adoption of bylaws.

Corporations organized under this chapter shall not have capital stock, but shall have members as prescribed and contemplated by the terms and provisions of this chapter; and such members shall have the privileges provided for in this chapter. The subscribers to the articles of incorporation as the organizers of the corporation shall have power to elect the first board of directors, who shall serve for the terms prescribed in the next sentence of this section, or until their successors are elected and qualified. One-third (⅓) of the members of the first board of directors shall be elected for a term of one (1) year, one-third (⅓) for a term of two (2) years, and one-third (⅓) for a term of three (3) years. Thereafterwards, directors shall be elected for terms of three (3) years. Provisions shall be made for subsequent elections of directors, including the time and place of such elections and notice thereof to the membership by (a) resolution of the directors entered upon the minutes not less than sixty (60) days before such election, designating the time and place of such election, such minutes to be open to the membership as hereinafter provided, or (b) by the time and place of such election being fixed by resolution of the directors, and notice thereof being mailed to the members at least fifteen (15) days before the time fixed for such election. All minutes of the corporation with respect to the time and place fixed for any such election of directors shall be open to members at all reasonable times, but no notice of elections shall be necessary, other than as herein provided. Each member shall be entitled to one (1) vote in the election of directors. It shall be the duty of the directors to provide for elections as the terms of office of directors expire, and it shall be the duty of the Commissioner of Insurance as a part of his supervisory jurisdiction over such corporations to see that the directors faithfully perform this duty. If such directors shall fail to so provide for the election of directors, it shall be the duty of the Commissioner of Insurance to report this fact to the membership of the corporation and himself call a meeting of the membership for the election of directors; and the corporation shall forthwith, upon demand of the commissioner, reimburse him for all expenses incurred in the performance of these duties. A majority vote of the members present in person (or by proxy, if proxy be provided for) and voting shall be required and shall be sufficient for the election of directors.

The membership of the corporation shall consist of any individual who has applied for, or been granted, a license to practice medicine in the State of Mississippi, or any other state or jurisdiction, provided he has first applied for membership on the form prescribed by the board of directors and paid the requisite fees, charges and premiums in advance therefor, and agreed to comply with and be bound by the charter and bylaws and amendments thereto, and the rules, regulations and guidelines adopted from time to time by the board of directors or any committee authorized by the board of directors to so act.

No person may own more than one (1) membership in the corporation, nor shall any member be entitled to more than one (1) vote upon any matter submitted to a vote at the meeting of the members.

Membership shall not be granted until a membership certificate in the form prescribed by the board of directors shall have been duly issued.

The event of (a) death, or (b) revocation of license to practice medicine, or (c) nonpayment of membership fees, dues, assessments or premiums, or (d) failure to comply with and abide by all provisions of the charter and bylaws and amendments thereto, and the rules, regulations and guidelines adopted from time to time by the board of directors or (e) termination of insurance with the corporation for any reason, shall operate ipso facto to terminate membership in the corporation, and all interest of any such member in the assets of the corporation shall then and thereby terminate and cease, except for the right to receive benefits provided for under contracts or the bylaws of the corporation.

The directors shall have power to adopt bylaws, elect officers and manage the affairs of the corporation. They shall also have the power to determine whether voting in the election of directors may be done by proxy and, if so, the manner and method thereof.

HISTORY: Laws, 1977, ch. 491, § 3; Laws, 1995, ch. 372, § 2, eff from and after passage (approved March 15, 1995).

§ 83-47-7. Establishing minimum capital and reserve; enforcement by injunction or mandamus.

(1) Each corporation established under the provisions of this chapter shall

furnish to the commissioner of insurance all information that he may request concerning the number of members of any such corporation and the type of practice of each such member. After considering the number of members and the type of practice of each such member, the commissioner of insurance shall require a minimum capital of Five Hundred Thousand Dollars ($500,000.00) and a minimum surplus of Five Hundred Thousand Dollars ($500,000.00) for such corporation. All dues, fees and assessments to any member of the corporation shall be set and maintained at the lowest possible cost subject to sound business practice and shall be subject to review and approval of the commissioner of insurance. No corporation established under the provisions of this chapter shall transact any other business than that specified in its charter and articles of incorporation; and it shall not begin operation until it has fully complied with all rules and regulations promulgated by the commissioner of insurance with respect to such corporations and until it has established the capital and reserve set for it by the commissioner.

(2) When necessary to effect the purposes of this section, in addition to all other remedies in law or equity, the attorney general and commissioner of insurance may be and are hereby authorized to petition the chancery court of the county in which a corporation established under this chapter is domiciled for a mandamus or injunction to prevent any violation of the provisions of this section, or the continuance of any such violation, or to enforce compliance herewith. The court is hereby vested with authority to entertain jurisdiction on any such petition to determine the cause and to issue such process as may be necessary to accomplish the purposes of this section.

HISTORY: Laws, 1977, ch. 491, § 4, eff from and after passage (approved April 15, 1977).

§ 83-47-9. Dues, fees and assessments; separate classes and groupings for fixing assessments of members; premium taxes.

Each member shall pay all dues, fees and assessments in such amounts as may be established from time to time by the resolution of the board of directors. The board of directors shall have the authority to provide for separate and distinct classes of insurance and groupings of members and insureds and to fix assessments and premiums at varying and different amounts for the various classes. No member or insured shall refuse or neglect to pay his or its assessment or premium because the amount thereof differs or varies from the amount of the assessment or premium of members in other classes or groupings. The board of directors shall endeavor to establish and fix assessments and premiums for the various classes and groupings which are reasonable in amount, relative to the benefits to be received by those members and insureds within the classes and groupings involved, and the action of the board of directors in so doing shall be conclusive and final. Each member shall also pay all obligations which may, from time to time, become due and payable by such member to the corporation as and when the same shall become due and payable. Such fees, assessments and premiums required of members and insureds shall contain an amount sufficient to pay three percent (3%) premium tax, the same as levied on all other domestic nonprofit insurance corporations. Such premium taxes shall be collected and paid into the treasury by the State Tax Commission.

HISTORY: Laws, 1977, ch. 491, § 5; Laws, 1982, ch. 351, § 18; Laws, 1995, ch. 372, § 3, eff from and after passage (approved March 15, 1995).

Editor's Notes — Section 20 of ch. 351, Laws of 1982, effective July 1, 1982, provides as follows:

"SECTION 20. Nothing in this act shall affect or defeat any claim, assessment, appeal, suit, right or cause of action for taxes due or accrued under any section contained herein prior to the date on which this act becomes effective, whether such assessments, appeals, suits, claims or actions shall have been begun before the date on which this act becomes effective, or shall thereafter be begun; and the provisions of any section contained herein are expressly continued in full force, effect and operation for the purpose of the assessment and collection of any taxes due or accrued thereunder prior to the date on which this act becomes effective, or the filing of reports, and for the imposition of any penalties, forfeitures or claims for failure to comply therewith."

Section 27-3-4 provides that the terms "'Mississippi State Tax Commission,' 'State Tax Commission,' 'Tax Commission' and 'commission' appearing in the laws of this state in connection with the performance of the duties and functions by the Mississippi State Tax Commission, the State Tax Commission or Tax Commission shall mean the Department of Revenue."

§ 83-47-11. Liability of members for debts of corporation; exemption of private property from execution.

The private property of the members of the corporation shall be exempt from the execution for the debts of the corporation, and no member shall be individually liable or responsible for any debts or liabilities of the corporation.

HISTORY: Laws, 1977, ch. 491, § 6, eff from and after passage (approved April 15, 1977).

§ 83-47-13. Annual statement.

Every such corporation shall annually, on or before the first day of March, file in the office of the commissioner of insurance a statement verified by at least two (2) of the principal officers of said corporation, showing its condition on the thirty-first day of December of the preceding year, which shall be in such form and shall contain such matters as the commissioner shall prescribe.

HISTORY: Laws, 1977, ch. 491, § 7, eff from and after passage (approved April 15, 1977).

§ 83-47-15. Investigation of affairs of corporation; access to books and documents; summoning and examining witnesses under oath.

The commissioner of insurance may appoint any deputy or examiner or other person who shall have the power of visitation and examination into the affairs of any such corporation and free access to all of the books, papers and documents that relate to the business of the corporation, and may summon and qualify witnesses under oath to examine its officers, agents, employees or other persons in relation to the affairs, transactions and conditions of the corporation.

HISTORY: Laws, 1977, ch. 491, § 8, eff from and after passage (approved April 15, 1977).

§ 83-47-17. Dissolution or liquidation of corporation.

Any dissolution or liquidation of a corporation, subject to the provisions of this chapter, shall be conducted under the supervision of the commissioner of insurance, who shall have all power with respect thereto under the provisions of law with respect to the dissolution and liquidation of insurance companies.

HISTORY: Laws, 1977, ch. 491, § 9, eff from and after passage (approved April 15, 1977).

§ 83-47-19. Declaration of charitable status; exemption from taxation.

Every corporation organized pursuant to, or subject to, the provisions of this chapter is hereby declared to be a charitable and benevolent institution, and its funds and property shall be exempt from taxation, except from the premium tax levied in accordance with the provisions of this chapter and ad valorem taxes upon real estate and motor vehicles owned by it.

HISTORY: Laws, 1977, ch. 491, § 10; Laws, 1978, ch. 441, § 10, eff from and after July, 1978.

§ 83-47-21. Conversion of nonprofit and nonshare corporations into nonprofit medical liability insurance corporations.

Any corporation heretofore or hereafter organized and operating under Chapter 11, Title 79, Mississippi Code of 1972, desiring to become a nonprofit corporation of the kind and character described in this chapter, and to operate under and pursuant to the terms of this chapter, may convert its organization into such nonprofit corporation under this chapter in the following manner, to wit:

(a) File a written application with the commissioner of insurance annexing thereto copies of (i) its articles of incorporation or new or amended articles of incorporation; (ii) its bylaws; (iii) its form of contract between the corporation and members, showing the terms under which medical liability insurance is to be furnished to members; (iv) its contracts with members, showing a table of assessments and the benefits to which members are entitled; and (v) a financial statement of the corporation, including the amounts of contributions paid or agreed to be paid to the corporation for working capital, the name or names of each contributor, and the terms of each contribution.

(b) Submit any further data or evidence as may be required by the commissioner.

(c) The commissioner shall refer the corporation's articles of incorporation to the attorney general for his opinion as to whether the same meet the requirements of this chapter. The attorney general shall, if in order to do so, endorse his approval thereon and return the same to the commissioner of insurance. The commissioner shall thereupon endorse upon said articles of incorporation his certificate of approval, whereupon said corporation shall be deemed to be converted under and existing and operating pursuant to the terms of this chapter. The articles of incorporation bearing such approval of the attorney general and the commissioner shall be recorded in the offices of the commissioner of insurance and of the secretary of state in like manner as in this chapter provided for recording the articles of incorporation of a corporation organized under this chapter in the first instance.

HISTORY: Laws, 1977, ch. 491, § 11, eff from and after passage (approved April 15, 1977).

§ 83-47-23. Nonprofit medical liability insurance corporations not covered by insurance guaranty association law.

The organization as created under the authority of this chapter shall in no manner be covered under or included in the provisions of Sections 83-23-101 through 83-23-135.

HISTORY: Laws, 1977, ch. 491, § 12, eff from and after passage (approved April 15, 1977).

RESEARCH REFERENCES

Practice References.
Business Law Monographs, Volume IN2—Casualty and Liability Insurance (Matthew Bender).

§ 83-47-25. Procedure for converting nonprofit medical liability insurance corporation to stock insurance corporation.

(1) A corporation organized under this chapter may become a stock insurance corporation under such plan and procedure as may be approved by the Commissioner of Insurance.

(2) The Commissioner of Insurance shall approve any such plan or procedure if:

(a) It is equitable to the corporation's members;

(b) It is subject to approval by vote of not less than three-fourths (¾) of the corporation's current members voting thereon in person or by proxy at a meeting of members called for the purpose pursuant to such reasonable notice and procedure as may be approved by the Commissioner of Insurance; right to vote may be limited to members who hold policies at the time of the vote and whose policies have been in force for not less than one (1) policy year;

(c) The equity of each member in the corporation is determinable under a fair formula approved by the Commissioner of Insurance, which such equity shall be based upon not less than the corporation's entire surplus as reported in the corporation's annual statement to the Commissioner of Insurance, after deducting borrowed surplus funds, plus all nonadmitted assets;

(d) The members entitled to participate in the purchase of stock or distribution of assets shall include all current members who hold policies at the time of the vote and whose policies have been in force for not less than one (1) policy year;

(e) The plan gives to each member, as specified in paragraph (d) of this subsection (2), a preemptive right to acquire his proportionate part of all of the proposed capital stock of the corporation, within a designated reasonable period, and to apply upon the purchase thereof the amount of his equity in the corporation as determined under paragraph (c) of this subsection (2);

(f) Shares are so offered to members at a price not greater than to be thereafter offered to others;

(g) The plan provides for payment to each member not electing to apply his equity in the corporation for, or upon, the purchase price of stock to which the member is preemptively entitled of cash in the amount of his equity not so used for the purchase of stock, and which case payment, together with stock so purchased, if any, shall constitute full payment and discharge of the member's equity as a member of such corporation; and

(h) The plan, when completed, would provide for the converted corporation paid-in capital stock in an amount not less than the minimum paid-in capital required of a domestic stock insurer transacting like kinds of insurance, together with surplus funds in amount not less than one half (½) of such required capital.

(3) Once conversion under this section is complete, the converted corporation shall no longer be governed by this chapter and shall be governed by the provisions of the insurance laws of this state applicable to general liability insurers.

HISTORY: Laws, 1995, ch. 372, § 4, eff from and after passage (approved March 15, 1995).

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation, in (e), substituted "paragraph (d) of this subsection (2)" for "subsection (2)(d) of this section" and "paragraph (c) of this subsection (2)" for "subsection (2)(c) of this section." The Joint Committee ratified the correction at its August 10, 2022, meeting.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 70-73, 96-101.

CJS.
44 C.J.S., Insurance §§ 153 et seq.

CHAPTER 48.

MEDICAL MALPRACTICE INSURANCE AVAILABILITY ACT

Sec.
83-48-1 through 83-48-7. Repealed.
83-48-9. Repeal of Sections 83-48-1 through 83-48-7.

§§ 83-48-1 through 83-48-7. Repealed.

Repealed by operation of law effective July 31, 2008.

§ 83-48-1. [Laws, 2003, ch. 560, § 1; reenacted without change, Laws, 2005, ch. 539, § 1; reenacted without change, Laws, 2006, ch. 567, § 1, eff from and after passage (approved Apr. 24, 2006.)]

§ 83-48-3. [Laws, 2003, ch. 560, § 2; reenacted without change, Laws, 2005, ch. 539, § 2; reenacted without change, Laws, 2006, ch. 567, § 2, eff from and after passage (approved Apr. 24, 2006.)]

§ 83-48-5. [Laws, 2003, ch. 560, § 3; reenacted and amended, Laws, 2005, ch. 539, § 3; reenacted and amended, Laws, 2006, ch. 567, § 3; Laws, 2009, ch. 563, § 15, eff from and after passage (approved May 13, 2009.)]

§ 83-48-7. [Laws, 2003, ch. 560, § 4; reenacted without change, Laws, 2005, ch. 539, § 4; reenacted without change, Laws, 2006, ch. 567, § 4, eff from and after passage (approved Apr. 24, 2006.)]

Editor's Notes — Former § 83-48-1 provided the short title for Chapter 48, Title 83.

Former § 83-48-3 provided that the purpose of the chapter was to provide a temporary market of last resort to make necessary medical malpractice insurance available for certain hospitals or other health care facilities and licensed health care providers.

Former § 83-48-5 created the Medical Malpractice Insurance Availability Plan.

Former § 83-48-7 created an advisory council to serve the Tort Claims Board for matters pertaining to the Medical Malpractice Coverage Availability Plan.

§ 83-48-9. Repeal of Sections 83-48-1 through 83-48-7.

Sections 83-48-1, 83-48-3, 83-48-5 and 83-48-7, Mississippi Code of 1972, shall stand repealed from and after the transfer of the plan's assets and liabilities as provided in Section 83-48-5(6)(i).

HISTORY: Laws, 2005, ch. 539, § 7; reenacted and amended, Laws, 2006, ch. 567, § 5, eff from and after passage (approved Apr. 24, 2006).

Editor's Notes — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in a statutory reference. The reference "83-48-6(i)" was changed to "83-48-5(6)(i)." The Joint Committee ratified the correction at its May 31, 2006, meeting.

This section provided that Sections 84-48-1, 84-48-3, 84-48-5 and 84-48-7 would stand repealed from and after the transfer of the assets and liabilities of the Medical Malpractice Insurance Availability Plan as provided in Section 83-48-5(6)(i). The Tort Claims Board accepted a proposal in May 2008 to sell the Plan to a private entity, and the plan's assets and liabilities were transferred to the private entity by the end of July 2008.

CHAPTER 49.

LEGAL EXPENSE INSURANCE

Sec.

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§ 83-49-1. Purposes and construction of chapter.

The purposes of this chapter are to provide for legal expense insurance by the registration of prepaid legal services plans, to promote access to quality legal services at the lowest possible price, and to regulate the development and operation of prepaid legal services plans, and it is the intent of this legislature that this chapter be interpreted as liberally as necessary to accomplish these purposes.

HISTORY: Laws, 1983, ch. 474, § 1, eff from and after July 1, 1983.

JUDICIAL DECISIONS

1. Arbitration clauses.

Grant of partial summary judgment in favor of the individuals and against the corporation in an action involving prepaid legal services was proper where no valid, binding arbitration agreement existed in the prepaid legal expense agreement, Miss. Code Ann. § 83-49-1 et seq.; in essence, there was no clear showing that the parties had agreed to arbitration. Pre-Paid Legal Servs. v. Battle, 873 So. 2d 79, 2004 Miss. LEXIS 320 (Miss.), cert. denied, 543 U.S. 958, 125 S. Ct. 409, 160 L. Ed. 2d 321, 2004 U.S. LEXIS 7156 (U.S. 2004).

§ 83-49-3. Persons to whom chapter applies.

The provisions of this chapter shall apply to all persons, groups, fraternal or benevolent organizations, including, but not limited to, insurers, corporations, partnerships, trusts, labor, craft or other unions, or any other entities who propose to operate or are operating or participating in the operation of a prepaid legal services plan as such a plan is hereinafter defined.

HISTORY: Laws, 1983, ch. 474, § 2, eff from and after July 1, 1983.

§ 83-49-5. Definitions.

In this chapter, the following terms shall have the following meanings:

(a) "Sponsor" means any insurer, as defined in this section, or any other corporation organized for the exclusive purpose of establishing and operating prepaid legal services plans.

(b) "Prepaid legal services plan" or "plan" means any arrangement whereby responsibility is undertaken to provide or arrange for, or to pay for or reimburse any part of the cost of, any legal services for a consideration consisting in part of prepaid or periodic charges or dues; but the provisions of this chapter shall not apply to the benefits available under automobile club membership contracts and automobile liability insurance policies which supply limited legal services or reimbursement for legal services in automobile-related matters under certificates of authority issued by the Insurance Commissioner, or to any legal aid or other legal services program for the indigent, or to limited legal services supplied by professional education associations to their members, or to any employer-employee legal services plan which is excluded from the provisions of this chapter by the provisions of the Federal Employee Retirement Income Security Act of 1974, or any amendments thereto.

(c) "Legal services" means any services normally provided by an attorney, as well as the payment of court costs and related expenses incurred in the exercise of any right; but not including the payment of fines, penalties, judgments or assessments. "Legal services" shall not include any service provided by an attorney in regard to a tort action.

(d) "Advertising" means any communication, other than a solicitation, as hereinafter defined, to the public or any segment thereof by means of radio, television, newspaper, magazine, periodical, brochure, pamphlet, circular, or any other means, the apparent purpose or reasonable effect of which would be to convey information purporting to relate to or describe legal rights, legal services, attorneys or prepaid legal services plans.

"Solicitation" means any communication, written or oral, in person, or by means of telephone, radio, television, newspaper, magazine, periodical, brochure, circular, or otherwise, of any offer of coverage in a prepaid legal services plan, or invitation, or request to enroll in a prepaid legal services plan, or attempt to obtain consideration for the coverage of a prepaid legal services plan, or any other device, the apparent purpose or reasonable effect of which would be to induce the recipient thereof to enroll in, or pay any consideration for the coverage provided by, a prepaid legal services plan.

(e) "Commissioner" means the Insurance Commissioner of the State of Mississippi.

(f) "Subscriber" means any person who has been enrolled in a prepaid legal services plan and is entitled to receive the benefits provided in the plan.

(g) "Subscription contract" means any contract signed by an authorized representative of a prepaid legal services plan and an individual or an authorized representative of his group or employer or labor union or other entity with which he is affiliated, under which the individual becomes a subscriber to the plan.

(h) "Insurer," as defined in this chapter means an insurer licensed to transact life or casualty insurance in this state.

HISTORY: Laws, 1983, ch. 474, § 3; Laws, 1997, ch. 307, § 7; Laws, 2009, ch. 336, § 1, eff from and after passage (approved Mar. 16, 2009).

Federal Aspects — Federal Employee Retirement Income Security Act of 1974, see 29 USCS §§ 1001 et seq.

§ 83-49-7. License required for sponsor other than insurer; fee; disclosure of business relationships; denial of license.

(1) No person other than an insurer as defined herein shall act as a sponsor nor enter into any contract with an individual person or persons whereby such person or persons become subscribers to a prepaid legal services plan without first having obtained a license from the commissioner to act as sponsor of prepaid legal services in this state.

(2) The annual license fee shall be One Hundred Fifty Dollars ($150.00). The fee for said license shall be paid to the commissioner for the use of the state on or before March 1 of each year.

(3) Before any licensee changes his address, he shall return his license to the commissioner who shall endorse the license indicating the change.

(4) The person to whom the license or the renewal thereof may be issued shall file sworn answers, subject to the penalties of perjury, to such interrogatories as the commissioner may require. The commissioner shall have authority, at any time, to require the applicant to disclose fully the identity of all

stockholders, partners, officers and employees, and he may, in his discretion, refuse to issue or renew a license in the name of any firm, partnership or corporation if he is not satisfied that any officer, employee, stockholder or partner thereof who may materially influence the applicant's conduct meets the standards of this chapter.

HISTORY: Laws, 1983, ch. 474, § 4, eff from and after July 1, 1983.

Cross References — Definition of "insurer," see § 83-49-5.

Revocation, suspension or refusal to renew license, see § 83-49-11.

Capitalization requirements for sponsors other than insurers as condition of license; see § 83-49-23.

License or representative of sponsor, see § 83-49-47.

Penalty for perjury, see § 97-9-61.

§ 83-49-9. Investigation of sponsor license applicants; qualifications for license; notice of denial; hearing.

Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and shall issue a license if he finds the applicant is qualified in accordance with this chapter. If the commissioner does not so find, he shall, within ninety (90) days after he has received such application, so notify the applicant and, at the request of the applicant, give the applicant a full hearing.

The commissioner shall issue or renew a license as may be applied for when he is satisfied that the person to be licensed:

(a) Is competent and trustworthy and intends to act in good faith as a sponsor of prepaid legal services plans in this state;

(b) Has a good business reputation and has had experience, training or education so as to be qualified to act as a sponsor of prepaid legal services plans; and

(c) If a corporation is incorporated under the laws of this state or a foreign corporation authorized to transact business in this state.

HISTORY: Laws, 1983, ch. 474, § 5, eff from and after July 1, 1983.

Cross References — Capitalization required of sponsor other than insurer as condition to issuance of license, see § 83-49-23.

Investigation of applicants for license as agent or representative of sponsor, see § 83-49-47.

§ 83-49-11. Revocation, suspension or refusal to renew sponsor's or representative's license; grounds; procedure; alternative penalties; subsequent application; review.

The commissioner may revoke or suspend or refuse to renew the license of any sponsor or representative of such sponsor when and if after investigation the commissioner finds that:

(a) Any license issued to such sponsor or representative of such sponsor was obtained by fraud;

(b) There was any misrepresentation in the application for the license;

(c) The sponsor or representative of such sponsor has otherwise shown itself untrustworthy or incompetent to act as a sponsor or representative of such sponsor;

(d) Such sponsor or representative of such sponsor has violated any of the provisions of this chapter or of the rules and regulations of the commissioner;

(e) The sponsor or representative of such sponsor has misappropriated, converted, illegally withheld, or refused to pay over upon proper demand any moneys entrusted to the sponsor or representative of such sponsor in its fiduciary capacity belonging to an insurer or insured;

(f) The sponsor or representative of such sponsor is found to be in an unsound condition or in such condition as to render the future transaction of business in this state hazardous to the public; or

(g) The sponsor or representative of such sponsor is found guilty of fraudulent, deceptive, unfair or dishonest practices as defined in Section 83-5-35 or 83-5-45, Mississippi Code of 1972, or has been convicted of a felony.

Before any license shall be refused, suspended, revoked or the renewal thereof refused hereunder, the commissioner shall give notice of his intention so to do, by certified mail, return receipt requested, to the applicant for or holder of such license and to any sponsor whom such representative represents or who desires that he be licensed, and shall set a date not less than twenty (20) days from the date of mailing such notice when the applicant or licensee and a duly authorized representative of the sponsor may appear to be heard and produce evidence. In the conduct of such hearing, the commissioner or any regular salaried employee specially designated by him for such purposes shall have power to administer oaths, to require the appearance of and examine any person under oath, and to require the production of books, records or papers relevant to the inquiry upon his own initiative or upon the request of the applicant or licensee. Upon the termination of such hearing, findings shall be reduced to writing and, upon approval by the commissioner, shall be filed in his office; and notice of the findings shall be sent by certified mail to the applicant or licensee and the sponsor concerned.

No licensee whose license has been revoked hereunder shall be entitled to file another application for a license as a sponsor or a representative of any sponsor within one (1) year from the effective date of such revocation. Such application, when filed, may be refused by the commissioner unless the applicant shows good cause why the revocation of his license shall not be deemed a bar to the issuance of a new license.

In lieu of revoking, suspending or refusing to renew the license for any of the causes enumerated in this section, after hearing as herein provided, the commissioner may place the sponsor on probation for a period of time not to exceed one (1) year, or may fine such sponsor not more than One Thousand

Dollars ($1,000.00) for each offense, or both, when in his judgment he finds that the public interest would not be harmed by the continued operation of the sponsor. The amount of any such penalty shall be paid by such sponsor to the commissioner for the use of the state. At any hearing provided by this section, the commissioner shall have authority to administer oaths to witnesses. Anyone testifying falsely, after having been administered such oath, shall be subject to the penalty of perjury.

Any action of the commissioner taken pursuant to the provisions of this section shall be subject to review as may be provided in Section 83-17-125.

HISTORY: Laws, 1983, ch. 474, § 6, eff from and after July 1, 1983.

Editor's Notes — Section 83-17-125, referenced in the last paragraph, was repealed by Laws of 2001, ch. 510, § 34, effective from and after January 1, 2002.

Cross References — Application of §§ 83-5-29 through 83-5-51 to sponsors, see § 83-49-21.

Capitalization requirements of sponsors other than insurers as condition of license, see § 83-49-23.

Promulgation of rules and regulations, see § 83-49-35.

Penalty for perjury, see § 97-9-61.

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any felony violation, see § 99-19-73.

RESEARCH REFERENCES

Am. Jur.

14 Am. Jur. Pl & Pr Forms (Rev), Insurance Form 11.1 (petition or application by insurance company against state commissioner of insurance to enjoin further proceedings to suspend or revoke insurance company's certificate of authority).

§ 83-49-13. Subscription contract; required contents; referrals to attorneys; filing and approval of contracts.

(1) Any sponsor of any prepaid legal services plan, or authorized representative thereof, may enter into a subscription contract with any person, or with any person's employer, or with any other person or group acting in his or its behalf; provided, however, that:

(a) No such subscription contract shall be written for a period longer than three (3) years; and

(b) In the case of subscription contracts issued to groups, no member of the group shall be bound by the subscription contract unless he indicates in writing to the group no earlier than ten (10) days after the date on which he has received effective notice of the terms and benefits of the plan and the intention of his group to contract for such plan that he does wish to become a subscriber and to be bound by the subscription contract. The notice received by such member shall contain, without limitation, the provisions itemized in subsection (2) hereinbelow.

(2) Every subscription contract shall be in writing and shall contain the following provisions:

(a) A brief statement of the plan's financial structure, including a statement of the amount of any premiums, charges or dues to be charged or currently being charged and the manner in which such amount is to be paid;

(b) A statement of the amount of benefits, reimbursement or indemnity to be furnished to each subscriber, and the period during which it will be furnished; and, if there are exceptions, reductions, exclusions, limitations or restrictions of such benefits reimbursement or indemnity, a detailed statement of such exceptions, reductions, exclusions, limitations or restrictions;

(c) A statement of the terms and conditions upon which the subscription contract may be cancelled or otherwise terminated by the sponsor or by the subscriber or by his employer or by his group. Provided, that any such cancellation or termination by the sponsor shall not become effective unless accomplished in accordance with the provisions of Sections 83-11-5, 83-11-9, 83-11-13, 83-11-15, 83-11-17, 83-11-19 and 83-11-21;

(d) A statement describing the applicability or nonapplicability of the benefits of the plan to the family dependents of the subscriber;

(e) A statement of the period of grace which will be allowed the subscriber or his employer or group for making any payment due under the subscription contract, which period shall not be less than twenty (20) days;

(f) A statement describing a procedure for settling disputes between or among the sponsor, participating or staff attorneys, and the subscribers;

(g) A statement that the subscription contract includes the endorsements thereon and attached papers, if any, and contains the entire contract; and

(h) A statement that no statements by the subscriber or his employee or group in the application for the contract shall void the subscription contract or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such subscription contract.

(3) A sponsor may provide a benefit plan which would provide only a telephone service for advice or consultation. Such telephone service shall not recommend a particular attorney to the subscriber.

(4) A sponsor may provide a benefit plan which would provide legal service including telephone advice or consultation which may recommend an attorney to the subscriber.

(5) Every subscriber shall be furnished a copy of his subscription contract, and every employer or other group shall be furnished a copy of the subscription contract signed by it.

(6) The sponsor shall be required to file a "specimen" copy of each subscription contract it uses, and a copy of its underwriting rules with the commissioner and a copy thereof shall also be sent to the Mississippi Bar by the sponsor. Such filings shall be approved by the commissioner before being used, however, such filings with the commissioner shall be deemed approved ninety (90) days after the date such filing is received by the commissioner, unless, prior to the expiration of said ninety-day period, the commissioner notified the sponsor of the prepaid legal services plan in writing of the commissioner's disapproval. The commissioner shall require that all such subscription contracts shall be fair and reasonable, and shall not approve any

subscription contracts or underwriting rules that are unfair or inequitable or contrary to the public policy of this state, or would, because such provisions are unclear or deceptively worded or encourage misrepresentation.

HISTORY: Laws, 1983, ch. 474, § 7; Laws, 1997, ch. 442, § 1, eff from and after passage (approved March 25, 1997).

Cross References — State bar association generally, see §§ 73-3-101 et seq.

JUDICIAL DECISIONS

1. Arbitration clauses.

Grant of partial summary judgment in favor of the individuals and against the corporation in an action involving prepaid legal services was proper where no valid, binding arbitration agreement existed in the prepaid legal expense agreement, Miss. Code Ann. § 83-49-1 et seq.; in essence, there was no clear showing that the parties had agreed to arbitration. Pre-Paid Legal Servs. v. Battle, 873 So. 2d 79, 2004 Miss. LEXIS 320 (Miss.), cert. denied, 543 U.S. 958, 125 S. Ct. 409, 160 L. Ed. 2d 321, 2004 U.S. LEXIS 7156 (U.S. 2004).

§ 83-49-15. Contracts for additional insurance or administrative services; approval.

(1) The sponsor of any prepaid legal services plan, or authorized representative thereof, may contract with any company licensed to transact life or casualty insurance in this state, under which contracts such company agrees, for a consideration consisting of a specified premium to assume the monetary obligations of the plan to provide or pay for the legal services covered by the subscription contracts issued under such plan, upon the failure of the plan itself to meet such obligations within a specified period. The duration of such contracts shall not be longer than three (3) years, and every such contract shall be filed with and subject to the approval of the commissioner for the fairness of its terms and premiums. The contracts shall be deemed approved ninety (90) days after date of filing with the commissioner, unless, prior to the expiration of such ninety-day period, the commissioner notifies the sponsor of the prepaid legal services plan in writing of the commissioner's disapproval. Any sponsor entering into such contracts shall fairly disclose to all subscribers affected by them the nature and extent of the extra protection provided by them. Any plan having lawful access to any other source of funds besides the premiums collected, which may be used to meet the obligations of the plan under its subscription contracts, shall make similar fair disclosure to affected subscribers.

(2) Any sponsor of any prepaid legal services plan, or authorized representative thereof, may contract with any person to provide administrative services necessary to the administration of the plan and the subscription contracts issued thereunder. The duration of such contracts shall not be longer than three (3) years, and every such contract shall be filed with and subject to the approval of the commissioner as to the fairness of its terms. The contracts shall be deemed approved ninety (90) days after the date of filing with the

commissioner unless, prior to the expiration of such ninety-day period, the commissioner notifies the sponsor of the prepaid legal services plan in writing of the commissioner's disapproval.

HISTORY: Laws, 1983, ch. 474, § 8; Laws, 1997, ch. 307, § 8, eff from and after July 1, 1997.

§ 83-49-17. Approval of underwriting rules and premiums; factors for consideration; conformity with state laws.

(1) No sponsor of any prepaid legal services plan, or authorized representative thereof, shall enter into any contract with subscribers unless and until the sponsor has filed with the commissioner a copy of its underwriting rules and a full schedule of the rates, premiums or membership fees to be charged to the subscribers. These filings shall be deemed to be approved by the commissioner ninety (90) days after the date of filing with the commissioner, unless, prior to the expiration of the ninety-day period, the commissioner notifies the sponsor of the prepaid legal services plan in writing of the commissioner's disapproval.

(2) In considering whether or not to approve a given rate schedule, the commissioner shall consider the following factors:

(a) Whether the rates are adequate to insure that all the benefits contracted for will be supplied;

(b) Whether the rates are excessive;

(c) Whether the rates are unfairly discriminatory; and

(d) Whether the rates are otherwise contrary to the laws or public policies of this state.

(3) In determining whether the rates to be charged are excessive, unfairly discriminatory, inadequate or otherwise contrary to the laws or public policies of this state, consideration shall be given to the past and prospective loss and countrywide expense experience, to all factors reasonably attributable to the class of risk, to a reasonable margin for profit and contingencies, to subscribers' or policyholders' dividends, savings or unabsorbed premium deposits allowed or returned by an insurer or sponsor to its policyholders, members or subscribers and investment income.

The systems of expense provisions included in the rates for use by any insurer, group of insurers or sponsor may differ from those of other insurers, group of insurers or sponsors, to reflect the requirements of the operating method of any insurer, group of insurers or sponsors with respect to any kind of insurance, or with respect to any subdivision or combination thereof for which the subdivision or combination of separate expense provisions are applicable.

Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards, or in experience, or in expense provisions, or in all three (3) factors.

Except to the extent necessary to meet the provisions of subsection (1) of this section, uniformity among insurers or sponsors in any matters within the scope of this section is neither required nor prohibited.

(4) Insurers licensed to transact life or casualty insurance in this state are required to comply with the requirements of this section if they sell or offer for sale policies of prepaid legal services plans of sponsors licensed to operate prepaid legal services plans in this state. Provided, that nothing contained herein shall be deemed to relieve any insurer authorized to transact life or casualty insurance in this state from complying with the requirements of Title 83, Mississippi Code of 1972, and other laws of this state.

HISTORY: Laws, 1983, ch. 474, § 9; Laws, 1997, ch. 307, § 9, eff from and after July 1, 1997.

Cross References — When policies of insurance approved under this section may be issued by insurers, see § 83-49-43.

§ 83-49-19. Advertising standards.

All advertising and solicitation concerning prepaid legal services plans shall be conducted in a simple, dignified manner. Every item of advertising or solicitation shall conform with the following standards:

(a) The form and content of any advertisement or solicitation shall be accurate and shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the commissioner from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed, or within a segment of the public to which such advertisement may be reasonably calculated to reach.

(b) All advertisements and solicitations shall be truthful and not misleading in fact or in implication. Words or phrases, the meaning of which is clear only by implications or by familiarity with insurance terminology, shall not be used.

(c) Advertising and solicitation which include references to the legal rights or remedies of citizens shall be legally accurate.

(d) Advertising and solicitation which include references to the particular characteristics of one or more sponsors or prepaid legal services plans, or which compare one or more sponsors or prepaid legal services plans, shall be truthful and not misleading.

(e) No such advertising or solicitation shall contain the name, address, telephone number or any other identifying information about any attorney, and no such advertising or solicitation shall extol the alleged virtues or qualifications or point out the alleged shortcomings of any attorney, whether named or not.

HISTORY: Laws, 1983, ch. 474, § 10, eff from and after July 1, 1983.

Cross References — Inclusion of advertising materials in annual report, see § 83-49-25.

§ 83-49-21. Provisions of §§ 83-5-29 through 83-5-51 applicable to plan sponsors.

The provisions of Sections 83-5-29 through 83-5-51 applicable to "insurers" shall apply to sponsors as defined in this chapter and for the purpose of determining whether a violation of Sections 83-5-29 through 83-5-51 has occurred, a "sponsor" as defined in this chapter shall be deemed to be a "person" as used in Sections 83-5-29 through 83-5-51, whichever is applicable.

HISTORY: Laws, 1983, ch. 474, § 11, eff from and after July 1, 1983.

§ 83-49-23. Capitalization of sponsors other than insurers; impairment.

No license or renewal license under this chapter shall be issued to a sponsor other than an insurer as defined herein, unless such sponsor:

(a) Shall possess as minimum capital and thereafter maintain a minimum balance of at least Five Thousand Dollars ($5,000.00) in its capital accounts as shown in its annual report to the commissioner. Provided, the commissioner shall, in his discretion, require such higher amounts of capital as he deems necessary for the protection of the public;

(b) Shall deposit with the commissioner securities acceptable to the commissioner in the amount of Twenty-five Thousand Dollars ($25,000.00), or shall file with the commissioner a bond to be approved by the commissioner and made payable to the commissioner or his successors in office executed by such applicant as principal and by a corporate surety authorized to do business in this state in the penal sum of Twenty-five Thousand Dollars ($25,000.00), conditioned that the sponsor will conduct his business in accordance with the provisions of this chapter and the laws of this state, and that the sponsor will properly account for all moneys collected in connection therewith. Such bond shall remain in full force and effect until the surety is released from liability by the commissioner or until the bond is cancelled by the surety and no such bond shall be cancelled or terminated unless prior to such cancellation or termination thirty (30) days' written notice is filed with the commissioner; and

(c) Shall maintain at all times a surplus, after deduction of reserves and exclusive of capital, of not less than twice the amount of capital required by paragraph (a), provided, however, in no case shall such surplus required to be maintained exceed Ten Thousand Dollars ($10,000.00). If at any time the surplus of such sponsor shall be less than the surplus set out in this paragraph, such sponsor shall be considered impaired; and it shall be the duty of the secretary-treasurer, directors and other proper officers of such sponsor to report any such impairment of surplus to the commissioner of insurance of this state in writing within ten (10) days after such impairment occurs. When any such impairment is reported, or if the commissioner of insurance should otherwise gain knowledge of the fact that the surplus of any such sponsor has been impaired, the commissioner shall forthwith suspend the certificate of authority or license of such sponsor to do business in this state until such sponsor shall raise or increase its surplus to the amount equal to that required herein.

HISTORY: Laws, 1983, ch. 474, § 12, eff from and after July 1, 1983.

Cross References — Requirement for license for sponsors other than insurers, see § 83-49-7.

Investigations of applications for licenses, see § 83-49-9.

Revocation, suspension or refusal to renew license, see § 83-49-11.

Disposition of deposits placed with commissioner, see § 83-49-41.

Reserve requirements, see § 83-49-49.

§ 83-49-25. Annual report; contents.

Every sponsor of a prepaid legal services plan shall, annually, on or before the first day of March, file in the office of the commissioner the following items:

(a) A statement, verified by at least two (2) of its principal officers or trustees, showing the financial condition of the plan on December 31 then next preceding, which shall be in such form and shall contain such matters as the commissioner shall prescribe;

(b) A statistical summary listing the numbers and types of claims paid and the average dollar amount of each type of claim;

(c) A list of the groups currently subscribing to the plan;

(d) A statement of the name, organizational form and principal place of business of the plan, and the name, organizational form and principal place of business of the sponsor of the plan;

(e) Copies of all advertising or solicitation material which the plan is using; and

(f) Such other pertinent and relevant information as the commissioner may reasonably require for the proper administration of this chapter. Provided, that all information furnished under this subsection (f) shall be kept confidential by the commissioner and shall not be made public by the commissioner or any other person, without the prior written consent of the sponsor or insurer to which it pertains unless the commissioner, after giving the sponsor or insurer who would be affected thereby, notice and opportunity to be heard, determines that the interests of the subscribers, policyholders, or the public will be served by the publication thereof, in which event he may publish all or any part thereof in such manner as he may deem appropriate, except to the extent that it may be produced in any judicial or administrative proceeding and may be admissible in evidence therein.

HISTORY: Laws, 1983, ch. 474, § 13, eff from and after July 1, 1983.

§ 83-49-27. Retention of records; inspection and report; expenses.

(1) The commissioner shall require every sponsor of a prepaid legal services plan to retain at the address shown on its license the plan-related books, records, accounts and vouchers for a term of five (5) years beginning immediately after the completion of the transaction and kept in such manner that the commissioner or his authorized representatives may readily verify its annual statements and determine whether the plan and the sponsor are in compliance with the law.

(2) The commissioner, or his designee, as often as the commissioner, in his sole discretion, deems appropriate but, at a minimum, at least every five (5) years shall visit each sponsor of a prepaid legal services plan and examine into such of its affairs as relate to the business of operating the plan. The commissioner shall have free access to all plan-related books, records, accounts and vouchers of the plan and may summon and examine under oath officers, trustees, agents and employees of the plan and any other persons regarding the affairs and condition of the plan. Provided, that no information, written or oral, need be supplied under this or any other subsection of this chapter in violation of the attorney-client privilege as it is construed by the courts of this state.

(3) Every sponsor of a plan being examined, its officers, employees and agents shall produce and make freely accessible to the commissioner the accounts, records, documents and files in its possession or control relating to the subject of the examination. Such officers, employees and agents shall facilitate such examination and aid the examiners as far as it is in their power in making the examination.

(4)(a) The commissioner shall make a full written report of each examination made by him containing only facts ascertained from the accounts, records and documents examined and from the sworn testimony of witnesses.

(b) The commissioner shall furnish a copy of the proposed report to the sponsor of the plan examined not less than twenty (20) days prior to filing the report. If such plan so requests in writing within such twenty-day period, or such longer period as the commissioner may grant, the commissioner shall grant a hearing with respect to the report, and shall not so file the report until after the hearing and such modifications have been made therein as the commissioner may deem proper.

(c) The commissioner may withhold from public inspection the report of any examination or investigation for so long as he deems it to be in the public interest or necessary to protect the plan examined from unwarranted injury.

(d) After the report has been filed, the commissioner may publish the report or the results thereof in one or more newspapers published in this state if he should deem it to be in the public interest.

(5) The sponsor of the plan so examined shall pay, at the direction of the commissioner, all the actual travel and living expenses of such examination.

When the examination is made by an examiner who is not a regular employee of the department, the sponsor examined shall pay the proper charges for the services of the examiner and his assistants in an amount approved by the commissioner. A consolidated account for the examination shall be filed by the examiner with the commissioner. No sponsor or other entity shall pay and no examiner shall accept any additional emolument on account of any examination. When the examination is conducted, in whole or in part, by regular salaried employees of the Department of Insurance, payment for such services and proper expenses shall be made by the sponsor examined to the commissioner, and such payment shall be deposited with the State Treasurer to the account of the Department of Insurance.

HISTORY: Laws, 1983, ch. 474, § 14; Laws, 1991, ch. 573, § 123; Laws, 2012, ch. 364, § 4, eff from and after July 1, 2012.

Cross References — Requirement that state officials pay over funds received to state treasury, see § 7-9-21.

Filing of annual statements, see § 83-49-25.

§ 83-49-29. Hearings and proceedings to be in conformity with §§ 83-17-123 et seq.

Except as otherwise provided in this chapter, all hearings and proceedings held under this chapter shall be conducted in accordance with the provisions of Section 83-17-123 et seq. and the commissioner shall have all the powers granted to him therein.

HISTORY: Laws, 1983, ch. 474, § 15, eff from and after July 1, 1983.

Editor's Notes — Sections 83-17-123 through 83-17-135, referred to in the section, were repealed by Laws of 2001, ch. 510, § 34, effective from and after January 1, 2002.

Cross References — Hearings on denial of sponsor's license, see § 83-49-9.

Hearings on revocation, suspension or refusal to renew sponsor's or representative's license, see § 83-49-11.

Hearings on denial of license to act as agent or representative of sponsor, see § 83-49-47.

§ 83-49-31. Injunctive relief against plans in violation of chapter; appointment of receivers; enforcement of criminal laws.

If the commissioner finds that any prepaid legal services plan operator or its sponsor (a) has failed to comply with any provision of this chapter; (b) is fraudulently operated; (c) is in such condition as to render further plan operations hazardous to the public interest or the interest of subscribers; (d) is financially unable to meet its obligations and claims as they come due; or (e) has violated any other provision of law, he may apply to the Circuit Court of the First Judicial District of Hinds County, State of Mississippi, for an injunction. The court may forthwith issue a temporary injunction restraining the transaction of any business by the plan, and it may, after a full hearing, make the injunction permanent, and appoint one or more receivers to take the plan to settle its affairs, and distribute its funds to those entitled thereto, subject to such rules and orders as the court may prescribe. If it appears that a crime has been committed in connection with the sale, advertisement, administration or management of any prepaid legal services plan, the attorney general of the State of Mississippi may pursue the appropriate criminal action.

HISTORY: Laws, 1983, ch. 474, § 16, eff from and after July 1, 1983.

Cross References — First judicial district of Hinds County, see §§ 9-7-23, 9-7-25.
Conjunctions generally, see §§ 11-13-1 et seq.

§ 83-49-33. Venue provisions applicable to sponsors.

The venue provisions applicable to "insurers" under Title 83, Chapters 19 and 21, Mississippi Code of 1972, shall apply to sponsors as defined in this chapter.

HISTORY: Laws, 1983, ch. 474, § 17, eff from and after July 1, 1983.

Cross References — Domestic insurance companies, see §§ 83-19-1 et seq.
Foreign insurance companies, see §§ 83-21-1 et seq.
Venue for injunctive relief from violations of this chapter and appointment of receivers, see § 83-49-31.

§ 83-49-35. Rules and regulations.

The commissioner shall have full power and authority to promulgate and adopt rules and regulations necessary for the implementation of this chapter.

HISTORY: Laws, 1983, ch. 474, § 18, eff from and after July 1, 1984.

Cross References — Revocation, suspension or refusal to renew license for violation of rules and regulations of commissioner, see § 83-49-11.

§ 83-49-37. Insurers to be in conformity with this chapter and other laws.

All insurers licensed to transact life or casualty insurance in this state who are licensed to issue policies of prepaid legal services insurance in this state shall be required to meet all the requirements of this chapter, unless specifically excepted therefrom by this chapter. Provided, that nothing contained herein shall be deemed to relieve the obligations of an insurer licensed to transact life or casualty insurance in this state from complying with the requirements of the Mississippi Code of 1972 and any other applicable laws of this state.

HISTORY: Laws, 1983, ch. 474, § 19; Laws, 1997, ch. 307, § 10, eff from and after July 1, 1997.

§ 83-49-39. Investment of funds.

A sponsor shall invest the funds of a prepaid legal services plan only in such investments as are authorized by the laws of this state for the investment of assets of domestic casualty insurance companies and subject to the limitations thereon or in such investments as are authorized by the laws of this state for the investment of assets of corporations authorized to transact business in this state pursuant to the provisions of Title 83, Mississippi Code of 1972, as the case may be.

HISTORY: Laws, 1983, ch. 474, § 20, eff from and after July 1, 1983.

Cross References — Investment of funds by domestic insurance companies, see §§ 83-19-51 through 83-19-55.

Foreign insurance companies generally, see §§ 83-21-1 et seq.

Investment of assets of mutual insurance companies, see § 83-31-29.

§ 83-49-41. Disposition of deposits.

Any deposits of a sponsor of a prepaid legal services plan deposited with the commissioner pursuant to the provisions of this chapter shall be administered by the commissioner in accordance with the provisions of the Mississippi Code of 1972 as though deposited by a domestic casualty insurer authorized to transact insurance in this state or as deposited by a corporation authorized to transact business in this state pursuant to the provisions of Chapter 19, Title 83, Mississippi Code of 1972, as the case may be.

HISTORY: Laws, 1983, ch. 474, § 21, eff from and after July 1, 1983.

Cross References — Deposits required of certain sponsors, see § 83-49-23.

§ 83-49-43. When subscription contracts may first be issued.

(1) No subscription contracts for prepaid legal services may be sold or offered for sale in this state prior to July 1, 1983. Provided, that nothing contained herein shall be deemed to prohibit an insurer authorized to transact life or casualty insurance in this state from selling or offering for sale in this state before July 1, 1983, individually underwritten and individually issued policies of prepaid legal services insurance on policy forms which have been approved by the commissioner pursuant to the provisions of the Mississippi Code of 1972, and Section 83-49-17.

(2) The provisions of this section shall not apply to any subscription contracts negotiated and issued in accordance with the provisions of Section 302(c) of the Labor Management Relations Act of 1947 (87 Stat. 314, 29 USC Section 186(c)(8)).

HISTORY: Laws, 1983, ch. 474, § 22, eff from and after July 1, 1983.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section 302(c)" for "section 302C" in the middle of (2). The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-49-45. Tax imposed on premiums; collection and enforcement.

(1) In addition to any license fee or tax now or hereafter provided by law, which shall be paid when the company or sponsor enters or is admitted to do business in this state, there is hereby levied and imposed upon all insurance companies and sponsors an additional annual license or privilege tax of three percent (3%) of the gross amount of premium receipts received from, and on prepaid legal services insurance policies and subscription contracts as defined in this chapter, written in or covering risks located in this state. In determining said amount of premiums, there shall be deducted therefrom premiums received for reinsurance from companies authorized to do business in this state, cash dividends paid under policy contracts or subscription contracts in this state, and premiums returned to policyholders or subscribers and cancellation on accounts of policies or subscription contracts not taken. The term "premium" as used herein shall also include policy fees, membership fees and monthly subscription contract charges and all other fees collected by the companies or sponsors. No credit or deduction from gross premium receipts shall be allowed for any commission, fee or compensation paid to any agent, solicitor or representative.

(2) Every insurance company or sponsor liable for the tax under the provisions hereof shall, quarterly each year as designated by the state tax commission, make and file with the state tax commission a full and correct statement, under oath of its president, secretary or other duly authorized officer at its home or head office in this country, of the gross amount of its premium receipts during the reporting period, and shall, at the time of filing such report, pay to the tax commission the tax levied hereby upon the premium collections for said period, computed as provided in subsection (1) of this section.

Every insurance company or sponsor liable for the payment of tax hereunder shall file an annual reconciliation statement of taxes paid during the previous year. The annual reconciliation statement shall be in the form prescribed by the state tax commission and shall be filed with the state tax commission on or before the last day of February following the close of each calendar year.

The state tax commission shall have the authority to promulgate rules and regulations, not inconsistent with this article, as it may deem necessary to enforce its provisions.

(3) If any insurance company, foreign or domestic, or sponsor shall fail to pay the tax imposed by this chapter at the time required therein, such company or sponsor shall be liable for the full amount of such tax, plus a penalty of twenty percent (20%) of the amount thereof, together with interest at the rate of twelve percent (12%) per annum from the due date of such taxes until same shall be paid.

(4) All taxes for which any company or sponsor is liable under the provisions of this chapter, and all penalties and interest due thereon, shall be collected and recovered by the state tax commission in the same manner provided by the law for the collection of sales taxes; and all administrative provisions of the Mississippi Sales Tax Law, including those which fix damages, penalties and interest for nonpayment of taxes, failure to file returns, and for other noncompliance with the provisions of said chapter, and all other requirements and duties imposed upon taxpayers, shall apply to all persons liable for taxes under the provisions of this chapter; and the state tax commission shall exercise all the power and authority to perform all the duties with respect to taxpayers under this section as are provided in the Mississippi Sales Tax Law, except that in cases that conflict with the provisions of this chapter, in which case the provisions of this chapter shall prevail.

HISTORY: Laws, 1983, ch. 474, § 23, eff from and after July 1, 1983.

Editor's Notes — Section 27-3-4 provides that the terms "'Mississippi State Tax Commission,' 'State Tax Commission,' 'Tax Commission' and 'commission' appearing in the laws of this state in connection with the performance of the duties and functions by the Mississippi State Tax Commission, the State Tax Commission or Tax Commission shall mean the Department of Revenue."

Cross References — Department of Revenue generally, see §§ 27-3-1 et seq.

Administration and enforcement of Sales Tax Law generally, see §§ 27-65-1 et seq.

§ 83-49-47. Agent or representative of sponsor; license required; fee; investigation; denial; grounds for issuance.

(1) No person shall act as a representative of a sponsor or agent of a sponsor as defined in Section 83-17-1, Mississippi Code of 1972, without first having obtained a license from the commissioner to act as an agent or representative of a sponsor of prepaid legal services in this state.

(2) The annual license fee shall be Ten Dollars ($10.00). The fee for said license shall be paid to the commissioner on or before March 1 of each year.

(3) Before any licensee changes his address, he shall return his license to the commissioner, who shall endorse the license indicating the change.

(4) Each person to whom the license or the renewal thereof may be issued shall file sworn answers, subject to the penalties of perjury, to such interrogatories as the commissioner may require. The commissioner shall have authority, at any time, to require the applicant to disclose fully the identity of all stockholders, partners, officers and employees, and he may, in his discretion, refuse to issue or renew a license in the name of any firm, partnership or corporation if he is not satisfied that any officer, employee, stockholder or partner thereof who may materially influence the applicant's conduct meets the standards of this chapter.

(5) Upon the filing of an application and the payment of the license fee, the commissioner shall make an investigation of each applicant and shall issue a license if he finds the applicant is qualified in accordance with this chapter.

If the commissioner does not so find, he shall, within ninety (90) days after he has received such application, so notify the applicant and, at the request of the applicant, give the applicant a full hearing.

(6) The commissioner shall issue or renew a license applied for when he is satisfied that the person to be licensed:

(a) Is competent and trustworthy and intends to act in good faith as an agent or representative of a sponsor of prepaid legal services plans in this state;

(b) Has a good business reputation and has had experience, training or education so as to be qualified to act as an agent or representative of a sponsor of prepaid legal services plans.

HISTORY: Laws, 1983, ch. 474, § 24, eff from and after July 1, 1983.

Cross References — Revocation, suspension or refusal to renew sponsor's or representative's license, see § 83-49-11.

§ 83-49-49. Reserve.

Any insurer or sponsor operating or writing a prepaid legal services plan in this state shall be required to set aside as a legal reserve to protect the holders of its policy or subscription contracts in this state the pro rata unearned portion of the premium paid for such contract, to be held until termination of such contracts.

HISTORY: Laws, 1983, ch. 474, § 25, eff from and after July 1, 1983.

Cross References — Capitalization requirements for sponsors other than insurers, see § 83-49-23.

CHAPTER 51.

DENTAL CARE BENEFITS

General Provisions. 83-51-1
Prohibitions Against Certain Provisions In Contracts Between Certain Health Care Entities and Dentists. 83-51-31

GENERAL PROVISIONS

Sec.
83-51-1. Definitions.
83-51-3. Provisions prohibited in health insurance policies and employee benefit plans.
83-51-5. Disclosure requirements; payments to non-contracting providers.
83-51-7. Provisions contrary to this chapter to be void.
83-51-9. Benefits not mandated.
83-51-11. Contracts between dentist and patient; authority of provider of health insurance policy or employee benefit plan.
83-51-13. Limitation of applicability of chapter.
83-51-15. Denial of claims; appeal; prior authorization.

§ 83-51-1. Definitions.

As used in this chapter, the following words have the meanings ascribed herein unless the context clearly requires otherwise:

(a) "Health insurance policy" means any individual, group, blanket or franchise insurance policy, insurance agreement or group hospital service contract which provides benefits for dental care expenses incurred as a result of an accident or sickness.

(b) "Employee benefit plan" means any plan, fund or program heretofore or hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, dental care benefits in the event of accident or sickness.

(c) "Dental care services" means those general and usual services furnished to any person for the purpose of preventing, alleviating, curing or healing human dental illness or injury as defined in Sections 73-9-1 through 73-9-65, Mississippi Code of 1972.

(d) "Dentist" means any person who furnishes dental care services and who is licensed as a dentist by the State of Mississippi.

(e) "Dental service contractor" means any person who accepts a prepayment from or for the benefit of any other person or group of persons as consideration for providing to such person or group of persons the opportunity to receive dental services at such times in the future as such services may be appropriate or required, but shall not be construed to include a dentist or professional dental corporation that accepts prepayment on a fee-for-service basis for providing specific dental services to individual patients for whom such services have been prediagnosed. Nothing in this paragraph (e) shall apply to a funded or self-funded trust qualified with the United States Department of Labor in accordance with Public Law 93-406, or the Division of Medicaid or any contractor of the division when providing services to eligible Medicaid beneficiaries.

(f) "Participant" means a dentist who has contracted with a dental service contractor to accept from and to look solely to such contractor for payment for any health care services rendered to a subscriber, subject to any co-payment obligations included in the contract of the subscriber with the dental service contractor.

(g) "Person" means an individual, insurer, association, organization, partnership, business, trust, except Employee Retirement Income Security Act (E.R.I.S.A.) trusts qualified with the United States Department of Labor under Public Law 93-406, corporation, or other legal entity.

(h) "Subscriber" means any person by or for whom a dental service contractor is paid a periodic premium as prepayment for dental services to be rendered to him by a participant.

(i) "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

HISTORY: Laws, 1985, ch. 369, § 1, eff from and after July 1, 1985; Laws, 2019, ch. 342, § 1, eff from and after July 1, 2019.

Federal Aspects — Employee Retirement Income Security Act (E.R.I.S.A.) generally, see 29 USCS § 1001 et seq.

OPINIONS OF THE ATTORNEY GENERAL

The Dental Care Benefits Law (Section 83-51-1 et seq.) is inapplicable to the Children's Health Insurance Program (CHIP), which is not under the jurisdiction of the Department of Insurance, but was, pursuant to Section 41-86-9, developed by the Children's Health Insurance Program Commission; thus, the School Employees Health Insurance Management Board (HIMB) is not prohibited from requiring that dentists meet certain minimum requirements in order to receive reimbursement for services rendered to children under CHIP, nor is HIMB prohibited from requiring that dentists participate in a provider network in order to receive reimbursement for services rendered to children under CHIP. Anderson and Dale, Dec. 6, 2002, A.G. Op. #02-0433.

§ 83-51-3. Provisions prohibited in health insurance policies and employee benefit plans.

No health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall:

(a) Prevent any person who is a party to or beneficiary of any such health insurance policy or employee benefit plan from selecting the dentist of his choice to furnish the dental care services offered by such policy or plan, or interfere with such selection, provided the dentist selected is licensed to furnish such dental care services in this state;

(b) Deny any dentist the right to participate as a contracting provider for such policy or plan, provided the dentist is licensed to furnish the dental care services offered by such policy or plan;

(c) Authorize any person to regulate, interfere or intervene in any manner in the diagnosis or treatment rendered by a dentist to his patient for the purpose of preventing, alleviating, curing or healing dental illness or injury, provided such dentist practices within the scope of his license; or

(d) Require that any dentist furnishing dental care services make or obtain dental x-rays or any other diagnostic aids for the purpose of preventing, alleviating, curing or healing dental illness or injury; provided, however, that nothing herein shall prohibit requests for existing dental x-rays or any other existing diagnostic aids for the purpose of determining benefits payable under a health insurance policy or employee benefit plan.

Nothing in this chapter shall prohibit the predetermination of benefits for dental care expenses prior to treatment by the attending dentist.

HISTORY: Laws, 1985, ch. 369, § 2, eff from and after July 1, 1985.

§ 83-51-5. Disclosure requirements; payments to non-contracting providers.

Any health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state shall, to the extent that it provides benefits for dental care expenses:

(a) Disclose, if applicable, that the benefit offered is limited to the least costly treatment;

(b) Define and explain the standard upon which the payment of benefits or reimbursement for the cost of dental care services is based, such as "usual and customary," "reasonable and customary," "usual, customary and reasonable," or fees or words of similar import, or it shall specify in dollars and cents the amount of the payment or reimbursement for dental care services to be provided. Payment or reimbursement for a non-contracting provider dentist shall be the same as the payment or reimbursement for a contracting provider dentist; provided, however, that the health insurance policy or the employee benefit plan shall not be required to make payment or reimbursement in an amount which is greater than the amount specified or which is greater than the fee charged by the providing dentist for the dental care services rendered.

HISTORY: Laws, 1985, ch. 369, § 3, eff from and after July 1, 1985.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in paragraph (b). The word "reimbursment" was changed to "reimbursement." The Joint Committee ratified the correction at its December 3, 1996, meeting.

§ 83-51-7. Provisions contrary to this chapter to be void.

Any provision in a health insurance policy or employee benefit plan which is delivered, renewed, issued for delivery, or otherwise contracted for in this state which is contrary to this chapter shall, to the extent of such conflict, be void.

HISTORY: Laws, 1985, ch. 369, § 4, eff from and after July 1, 1985.

§ 83-51-9. Benefits not mandated.

The provisions of this chapter do not mandate that any type of benefits for dental care expenses be provided by a health insurance policy or an employee benefit plan.

HISTORY: Laws, 1985, ch. 369, § 5, eff from and after July 1, 1985.

§ 83-51-11. Contracts between dentist and patient; authority of provider of health insurance policy or employee benefit plan.

Notwithstanding any other provision of this chapter:

(a) A dentist may contract directly with a patient for the furnishing of dental care services to such patient as may be otherwise authorized by law;

(b) Any person providing a health insurance policy or employee benefit plan, or an employer, or an employee organization may:

(i) Make available to its insureds, beneficiaries, participants, employees or members information relating to dental care services by distributing factually accurate information regarding dental care services, rates, fees, location and hours of service, provided such distribution is made upon the request of any dentist licensed by the state; or

(ii) Establish an administrative mechanism which facilitates payment for dental care services by insureds, beneficiaries, participants, employees or members to the dentist of their choice; or

(iii) Pay or reimburse, on a non-discriminatory basis, its insureds, beneficiaries, participants, employees or members for the cost of dental care services rendered by the dentist of their choice.

HISTORY: Laws, 1985, ch. 369, § 6, eff from and after July 1, 1985.

§ 83-51-13. Limitation of applicability of chapter.

The provisions of this chapter do not apply to Article 3, Chapter 41, Title 83, Mississippi Code of 1972, which provides for the organizing of nonprofit hospital, medical and surgical service corporations, and do not apply to the Nonprofit Dental Service Corporation Law or to employee benefit plans paid for completely by the employer covering the employee and his or her dependents.

HISTORY: Laws, 1985, ch. 369, § 7, eff from and after July 1, 1985.

Editor's Notes — Article 3, Chapter 41, Title 83, referred to in this section was repealed by Laws of 1997, ch. 307, effective July 1, 1997.

Cross References — Nonprofit Dental Service Corporation Law, see §§ 83-43-1 et seq.

§ 83-51-15. Denial of claims; appeal; prior authorization.

(1)(a) A dental service contractor or a contract of dental insurance shall establish and maintain appeal procedures for any claim by a dentist or a subscriber that is denied based upon lack of medical necessity.

(b) Any denial shall be based upon a determination by a dentist who holds a nonrestricted license issued in the United States in the same or an appropriate specialty that typically manages the dental condition, procedure, or treatment under review.

(c) Subsequent to an initial denial, the licensed dentist making the adverse determination shall not be an employee of the dental service contractor or dental insurer.

(d) Any written communication to an insured or a dentist that includes or pertains to a denial of benefits for all or part of a claim on the basis of a lack of medical necessity shall include the name, applicable specialty designation, license number together with state of issuance, and the email address of the licensed dentist making the adverse determination.

(2)(a) For the purposes of this subsection, a "prior authorization" shall mean any predetermination, prior authorization or similar authorization that is verifiable, whether through issuance of letter, facsimile, e-mail or similar means, indicating that a specific procedure is, or multiple procedures are, covered under the patient's plan and reimbursable at a specific amount, subject to applicable coinsurance and deductibles, and issued in response to a request submitted by a dentist using a prescribed format.

(b) A dental service contractor shall not deny any claim subsequently submitted for procedures specifically included in a prior authorization unless at least one (1) of the following circumstances applies for each procedure denied:

(i) Benefit limitations such as annual maximums and frequency limitations not applicable at the time of prior authorization are reached due to utilization subsequent to issuance of the prior authorization;

(ii) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

(iii) If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care;

(iv) If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time require disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was issued; or

(v) The dental service contractor's denial is because of one (1) of the following:

1. Another payor is responsible for the payment;

2. The dentist has already been paid for the procedures identified on the claim;

3. The claim was submitted fraudulently or the prior authorization was based in whole or material part on erroneous information provided to the dental service contractor by the dentist, patient, or other person not related to the carrier; or

4. The person receiving the procedure was not eligible to receive the procedure on the date of service and the dental service contractor did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status.

(c) A dental service contractor shall not require any information be submitted for a prior authorization request that would not be required for submission of a claim.

(d) A dental service contractor shall issue a prior authorization within thirty (30) days of the date a request is submitted by a dentist.

(e) The provisions of subsection (1) of this section shall apply to any denial of a claim pursuant to paragraph (b) of this subsection for a procedure included in a prior authorization.

(3) A contractor shall not recoup a claim solely due to a patient's loss of coverage or ineligibility if, at the time of treatment, the contractor erroneously confirms coverage and eligibility, but had sufficient information available to it indicating that the patient was no longer covered or was ineligible for coverage.

HISTORY: Laws, 2019, ch. 342, § 2, eff from and after July 1, 2019.

PROHIBITIONS AGAINST CERTAIN PROVISIONS IN CONTRACTS BETWEEN CERTAIN HEALTH CARE ENTITIES AND DENTISTS

Sec.

83-51-31. Prohibition against contract between certain health care entities and dentists from requiring that dentist provide services to subscribers at fee established by health care entity unless services are covered services under subscriber agreement.

§ 83-51-31. Prohibition against contract between certain health care entities and dentists from requiring that dentist provide services to subscribers at fee established by health care entity unless services are covered services under subscriber agreement.

No contract between a health care entity that offers a dental plan or plans and a dentist for the provision of services to subscribers may require that a dentist provide services to his subscribers at a fee set by the health care entity unless the services are covered services under the applicable subscriber agreement. For the purposes of this section, "covered services" means services that are reimbursable under the applicable subscriber agreement, notwithstanding any deductibles, waiting periods or frequency limitations that may apply. For the purposes of this section, "dental plan" means any policy of insurance that is issued by a health care entity that provides for coverage of dental services not in connection with a medical plan.

HISTORY: Laws, 2010, ch. 497, § 1; Laws, 2012, ch. 318, § 1, eff from and after July 1, 2012.

CHAPTER 52.

GUARANTEED ASSET PROTECTION WAIVERS

Sec.

83-52-1. Chapter purpose; applicability; waivers are not insurance and are exempt from insurance laws.
83-52-3. Definitions.
83-52-5. Offering, selling or providing GAP waivers to Mississippi borrowers authorized.
83-52-7. Insurance policies insuring GAP waivers; coverage to cover subsequent assignees; coverage to remain in effect unless cancelled or terminated.
83-52-9. Guaranteed asset protection waiver disclosures.
83-52-11. Guaranteed asset protection waiver agreement cancellation.
83-52-13. Inapplicability of Sections 83-52-5(3), 83-52-9 and 83-52-15 to certain GAP waivers.
83-52-15. Enforcement of this chapter and protection of Mississippi GAP waiver holders.

§ 83-52-1. Chapter purpose; applicability; waivers are not insurance and are exempt from insurance laws.

(1) The purpose of this chapter is to provide a framework within which guaranteed asset protection waivers are defined and may be offered within this state.

(2) This chapter does not apply to:

(a) An insurance policy offered by an insurer under the insurance laws of this state; or

(b) A debt cancellation or debt suspension contract being offered by any national or state-chartered bank or federal or state-chartered credit union in compliance with 12 CFR Part 37, or 12 CFR Part 721, or any other federal law.

(3) Guaranteed asset protection waivers governed under this chapter are not insurance and are exempt from the insurance laws of this state. Persons marketing, selling or offering to sell guaranteed asset protection waivers to borrowers who comply with this chapter are exempt from insurance licensing and insurance regulation requirements of this state.

HISTORY: Laws, 2018, ch. 417, § 1, eff from and after July 1, 2018.

§ 83-52-3. Definitions.

The following are terms defined for purposes of this chapter and are not intended to provide actual terms required in guaranteed asset protection waivers:

(a) "Administrator" means a person, other than an insurer or creditor, who issues, makes or provides a GAP waiver, or who performs administrative or operational functions pursuant to guaranteed asset protection waiver programs.

(b) "Borrower" means a debtor, retail buyer or lessee, under a finance agreement.

(c) "Commissioner" means the Commissioner of Insurance for the State of Mississippi.

(d) "Creditor" means:

(i) The lender in a loan or credit transaction;

(ii) The lessor in a lease transaction;

(iii) Any "retail seller" of motor vehicles that provides credit to "retail buyers" of such motor vehicles provided that such entities comply with the provisions of this chapter;

(iv) The seller in commercial retail installment transactions; or

(v) The assignees of any of the creditors listed in subparagraphs (i) through (iv) of this paragraph to whom the credit obligation is payable.

(e) "Finance agreement" means a loan, lease or retail installment sales contract for the purchase or lease of a motor vehicle or any other credit extension secured by a motor vehicle.

(f) "Free look period" means the period of time from the effective date of the GAP waiver until the date the borrower may cancel the contract without penalty, fees or costs to the borrower. This period of time shall not be shorter than thirty (30) days.

(g) "Guaranteed asset protection waiver" or "GAP waiver" means a contractual agreement wherein a creditor agrees for a separate charge to cancel or waive, or an administrator agrees for a separate charge to pay, all or part of amounts due on a borrower's finance agreement in the event of a total physical damage loss or unrecovered theft of the motor vehicle. A GAP waiver in which the creditor cancels or waives amount due shall be part of, or a separate addendum to, the finance agreement.

(h) "Insurer" means an insurance company licensed, registered, or otherwise authorized to do business under the insurance laws of this state.

(i) "Motor vehicle" means self-propelled or towed vehicles designed for personal or commercial use, including, but not limited to, automobiles, trucks, motorcycles, recreational vehicles, all-terrain vehicles, snowmobiles, campers, boats, personal watercraft, and motorcycle, boat, camper and personal watercraft trailers.

(j) "Person" includes an individual, company, association, organization, partnership, business trust, corporation, and every form of legal entity.

HISTORY: Laws, 2018, ch. 417, § 2, eff from and after July 1, 2018.

§ 83-52-5. Offering, selling or providing GAP waivers to Mississippi borrowers authorized.

(1) GAP waivers may be offered, sold or provided to borrowers in this state under this chapter.

(2) GAP waivers may, at the option of the creditor or administrator, be sold for a single payment or may be offered with a monthly or periodic payment option.

(3) Notwithstanding any other provision of law to the contrary, any cost to the borrower for a guaranteed asset protection waiver entered into in compliance with the Truth in Lending Act (15 USC 1601 et seq.) and its implementing regulations, as they may be amended from time to time, shall be separately stated and is not to be considered a finance charge or interest.

(4) A retail seller or administrator shall insure its GAP waiver obligations under a contractual liability or other insurance policy issued by an insurer. A creditor, other than a retail seller, may insure its GAP waiver obligations under a contractual liability policy or other such policy issued by an insurer. Any such insurance policy may be directly obtained by a creditor, retail seller, or may be procured by an administrator to cover a creditor's or retail seller's obligations. However, retail sellers that are lessors on motor vehicles are not required to insure obligations related to GAP waivers on such leased vehicles.

(5) The GAP waiver shall remain a part of the finance agreement upon the assignment, sale or transfer of such finance agreement by the creditor.

(6) Neither the extension of credit, the term of credit, nor the term of the related motor vehicle sale or lease may be conditioned upon the purchase of a GAP waiver.

(7) Any creditor or administrator that offers a GAP waiver shall report the sale of, and forward funds received on all such waivers to the designated party, if any, as prescribed in any applicable administrative services agreement, contractual liability policy, other insurance policy or other specified program documents.

(8) Funds received or held by a creditor or administrator and belonging to an insurer, creditor or administrator, pursuant to the terms of a written agreement, shall be held by such creditor or administrator in a fiduciary capacity.

HISTORY: Laws, 2018, ch. 417, § 3, eff from and after July 1, 2018.

Cross references — This section is not applicable to a guaranteed asset protection waiver offered in conjunction with a lease or retail installment sale associated with a commercial transaction, see § 83-52-13.

§ 83-52-7. Insurance policies insuring GAP waivers; coverage to cover subsequent assignees; coverage to remain in effect unless cancelled or terminated.

(1) Contractual liability or other insurance policies insuring GAP waivers shall state the obligation of the insurer to reimburse or pay to the creditor or administrator any sums the creditor is legally obligated to waive, or administrator is legally obligated to pay, under the GAP waivers issued by the creditor or administrator and purchased or held by the borrower.

(2) Coverage under a contractual liability or other insurance policy insuring a GAP waiver shall also cover any subsequent assignee upon the assignment, sale or transfer of the finance agreement.

(3) Coverage under a contractual liability or other insurance policy

insuring a GAP waiver shall remain in effect unless cancelled or terminated in compliance with applicable insurance laws of this state.

(4) The cancellation or termination of a contractual liability or other insurance policy shall not reduce the insurer's responsibility for GAP waivers issued by the creditor or administrator prior to the date of cancellation or termination and for which the premium has been received by the insurer.

HISTORY: Laws, 2018, ch. 417, § 4, eff from and after July 1, 2018.

§ 83-52-9. Guaranteed asset protection waiver disclosures.

Guaranteed asset protection waivers shall disclose, as applicable, in writing and in clear, understandable language that is easy to read, the following:

(a) The name and address of the initial creditor and the borrower at the time of sale, and the identity of any administrator if different from the creditor.

(b) The purchase price and the terms of the GAP waiver, including, without limitation, the requirements for protection, conditions, or exclusions associated with the GAP waiver.

(c) That the borrower may cancel the GAP waiver within a free look period as specified in the waiver, and will be entitled to a full refund of the purchase price, so long as no benefits have been provided.

(d) The procedure the borrower shall follow, if any, to obtain GAP waiver benefits under the terms and conditions of the waiver, including a telephone number and address where the borrower may apply for waiver benefits.

(e) Whether or not the GAP waiver is cancellable after the free look period and the conditions under which it may be cancelled or terminated, including the procedures for requesting any refund due.

(f) That in order to receive any refund due in the event of a borrower's cancellation of the GAP waiver agreement or early termination of the finance agreement after the free look period of the GAP waiver, the borrower, in accordance with terms of the waiver, shall provide a written request to cancel to the creditor, administrator or such other party. If the GAP waiver is cancelled due to the early termination of the finance agreement, the borrower must provide the request within ninety (90) days of the occurrence of the event terminating the finance agreement.

(g) The methodology for calculating any refund of the unearned purchase price of the GAP waiver due, in the event of cancellation of the GAP waiver or early termination of the finance agreement.

(h) That neither the extension of credit, the terms of the credit, nor the terms of the related motor vehicle sale or lease, may be conditioned upon the purchase of the GAP waiver.

HISTORY: Laws, 2018, ch. 417, § 5, eff from and after July 1, 2018.

Cross References — This section is not applicable to a guaranteed asset protection waiver offered in conjunction with a lease or retail installment sale associated with a commercial transaction, see § 83-52-13.

§ 83-52-11. Guaranteed asset protection waiver agreement cancellation.

(1) Guaranteed asset protection waiver agreements may be cancellable or noncancellable after the free look period. GAP waivers shall provide that if a borrower cancels a waiver within the free look period, the borrower will be entitled to a full refund of the purchase price, so long as no benefits have been provided; or in the event benefits have been provided, the borrower may receive a full or partial refund pursuant to the terms of the waiver.

(2) In the event of a borrower's cancellation of the GAP waiver or early termination of the finance agreement, after the agreement has been in effect beyond the free look period, the borrower may be entitled to a refund of any unearned portion of the purchase price of the waiver unless the waiver provides otherwise. In order to receive a refund, the borrower, in accordance with any applicable terms of the waiver, shall provide a written request to the creditor, administrator or other party. If the GAP waiver is cancelled due to the early termination of the finance agreement, the borrower must provide the request within ninety (90) days of the event terminating the finance agreement.

(3) If the cancellation of a GAP waiver occurs as a result of a default under the finance agreement or the repossession of the motor vehicle associated with the finance agreement, or any other termination of the finance agreement, any refund due may be paid directly to the creditor or administrator and applied as set forth in subsection (4) of this section.

(4) Any cancellation refund under subsection (1), (2) or (3) of this section may be applied by the creditor as a reduction of the amount owed under the finance agreement, unless the borrower can show that the finance agreement has been paid in full.

HISTORY: Laws, 2018, ch. 417, § 6, eff from and after July 1, 2018.

§ 83-52-13. Inapplicability of Sections 83-52-5(3), 83-52-9 and 83-52-15 to certain GAP waivers.

Sections 83-52-5(3), 83-52-9 and 83-52-15 of this chapter are not applicable to a guaranteed asset protection waiver offered in connection with a lease or retail installment sale associated with a commercial transaction.

HISTORY: Laws, 2018, ch. 417, § 7, eff from and after July 1, 2018.

§ 83-52-15. Enforcement of this chapter and protection of Mississippi GAP waiver holders.

The commissioner may take action which is necessary or appropriate to enforce the provisions of this chapter and to protect guaranteed asset protection waiver holders in this state. After proper notice and opportunity for hearing, the commissioner may:

(a) Order the creditor, administrator or any other person not in compliance with this chapter to cease and desist from further guaranteed asset protection waiver-related operations which are in violation of this chapter.

(b) Impose a penalty of not more than Five Hundred Dollars ($500.00) per violation and not more than Ten Thousand Dollars ($10,000.00) in the aggregate for all violations of similar nature. For purposes of this paragraph (b), violations shall be of a similar nature if the violation consists of the same or similar course of conduct, action, or practice, irrespective of the number of times the conduct, action, or practice which is determined to be a violation of this chapter occurred.

HISTORY: Laws, 2018, ch. 417, § 8, eff from and after July 1, 2018.

Cross References — This section is not applicable to a guaranteed asset protection waiver offered in conjunction with a lease or retail installment sale associated with a commercial transaction, see § 83-52-13.

CHAPTER 53.

CREDIT LIFE AND CREDIT DISABILITY INSURANCE

Sec.

83-53-1. Legislative purpose; construction.
83-53-3. Scope of chapter; definitions.
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83-53-9. Term of insurance.
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83-53-41. Appeal from order which does not charge violation.
83-53-43. Penalty for violation of final order; civil action to recover penalty.
83-53-45. Time for hearing.
83-53-47. Relation to other laws.

§ 83-53-1. Legislative purpose; construction.

The purpose of this chapter is to promote the public welfare by regulating credit life insurance and credit disability insurance. Nothing in this chapter is intended to prohibit or discourage competition which is in the public interest. The provisions of this chapter shall be liberally construed.

HISTORY: Laws, 1986, ch. 440, § 1, eff from and after May 1, 1986.

Cross References — Creditor-placed insurance under the Mississippi Creditor-Placed Insurance Act, see §§ 83-54-1 et seq.

JUDICIAL DECISIONS

1. In general.

Regulation adopted by Insurance Commissioner, requiring credit life insurers to substantiate loss ratio of 50% "at all ages (i.e., each age band)" before charging rates exceeding statutory rate, was inconsistent with statute allowing rate variance to be granted when loss ratio for particular class is at least 50%; accordingly, regulation was outside scope of Commissioner's power to promulgate. American Federated Life Ins. Co. v. Dale, 701 So. 2d 809, 1997 Miss. LEXIS 625 (Miss. 1997).

RESEARCH REFERENCES

ALR.

Failure of creditor, or creditor's assignee, to secure credit insurance as affecting rights or liabilities of debtor, upon debtor's loss. 88 A.L.R.3d 794.

Credit life insurer's punitive damage liability for refusing payment. 55 A.L.R.4th 246.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 23-65.

CJS.

44 C.J.S., Insurance §§ 76-143.

§ 83-53-3. Scope of chapter; definitions.

(1) All credit life insurance and all credit disability insurance sold in connection with loans or other credit transactions, including lease payments and residuals, shall be subject to the provisions of this chapter, except:

(a) Such insurance sold in connection with a loan or other credit transaction of more than ten (10) years' duration;

(b) Such credit life insurance sold in connection with a loan or other credit transaction of an agricultural cooperative financial institution authorized to do business in this state by any act of the Congress of the United States or by the laws of the State of Mississippi; and

(c) Such insurance where its issuance is an isolated transaction on the part of the insurer not related to an agreement or a plan or regular course of conduct for insuring debtors of the creditor.

(2) For the purposes of this chapter:

(a) "Commissioner" means the Commissioner of Insurance of the State of Mississippi;

(b) "Credit life insurance" means insurance on the life of a debtor pursuant to or in connection with a specific loan or other credit transactions, including lease payments and residual, exclusive of any such insurance procured at no expense to the debtor, and credit life insurance on agricultural credit transactions. Insurance shall be deemed procured at no expense to the debtor unless the cost of the credit transaction to the debtor varies depending on whether or not the insurance is procured;

(c) "Credit disability insurance" means insurance on a debtor to provide indemnity for payments becoming due on a specific loan or other credit transaction while the debtor is disabled as defined in the policy;

(d) "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights or privileges, for which payment is arranged through a credit transaction or any successor to the right, title or interest of any such lender, vendor or lessor, which lender, vendor or lessor is the beneficiary of any credit life insurance or credit disability insurance sold in connection with such credit transaction.

(e) "Debtor" means a borrower of money or a purchaser or lessee of goods, services, property, rights or privileges, for which payment is arranged through a credit transaction; and

(f) "Indebtedness" means the total amount payable by the debtor to a creditor in connection with a loan or other credit transaction.

(g) "Insurer" means an insurance company licensed in the State of Mississippi to write credit life insurance and credit disability insurance.

(h) "Insurance premium" shall include that portion collected or payable which is compensation as set forth in Section 83-53-25.

HISTORY: Laws, 1986, ch. 440, § 2, eff from and after May 1, 1986.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in paragraph (d) of subsection (2). The words "any such lender, vendor or lessor, which lendor" were changed to "any such lender, vendor or lessor, which lender." The Joint Committee ratified the correction at its May 20, 1998, meeting.

Cross References — Commissioner of Insurance generally, see § 83-1-3.

Provision that, for purposes of this chapter, the term "insurance premium" includes that portion collected or payable which is compensation as set forth in this section, see § 83-53-3.

RESEARCH REFERENCES

ALR.

Credit life insurer's punitive damage liability for refusing payment. 55 A.L.R.4th 246.

Am. Jur.

43 Am. Jur. 2d, Insurance § 522.

CJS.

45 C.J.S., Insurance § 1254.

§ 83-53-5. Permissible forms of insurance.

Credit life insurance and credit disability insurance shall be issued only in the following forms:

(a) Individual policies of life insurance issued to debtors on the term plan;

(b) Individual policies of disability insurance issued to debtors on a term plan or disability benefit provisions in individual policies of credit life insurance;

(c) Group policies of life insurance issued to creditors providing insurance upon the lives of debtors on the term plan; and

(d) Group policies of disability insurance issued to creditors on a term plan insuring debtors or disability benefit provisions in group credit life insurance policies to provide such coverage.

HISTORY: Laws, 1986, ch. 440, § 3, eff from and after May 1, 1986.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 183-206.

CJS.
44 C.J.S., Insurance §§ 384-406.

§ 83-53-7. Limitations on amount of insurance.

(1) The initial amount of credit life insurance shall not exceed the total amount repayable under the contract of indebtedness. In the case of revolving loan or revolving charge accounts, the insurance shall not at any time exceed the unpaid indebtedness.

Notwithstanding the provisions of the above paragraph, the amount of insurance on agricultural loan commitments may be equal to the amount of the loan commitment.

(2) The total amount of periodic indemnity payable by credit disability insurance, in the event of disability as defined in the policy, shall not exceed the aggregate of the periodic scheduled unpaid installments of indebtedness, and the amount of each periodic indemnity shall not exceed the total amount repayable divided by the number of periodic installments.

HISTORY: Laws, 1986, ch. 440, § 4, eff from and after May 1, 1986.

JUDICIAL DECISIONS

1. Total of payments.
It is not a violation of statute in Mississippi to calculate the amount of credit insurance on the total of payments; rather, by statute, this is permissible. Harrison v. Commercial Credit Corp., 2002 U.S. Dist. LEXIS 7959 (S.D. Miss. Mar. 28, 2002).

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance § 522.

CJS.
45 C.J.S., Insurance § 1254.

§ 83-53-9. Term of insurance.

The term of any credit life insurance or credit disability insurance shall commence on the date when the debtor becomes obligated to the creditor, or the date the debtor applies for such insurance, whichever is later, except that where a group policy provides coverage with respect to existing obligations, the insurance on a debtor with respect to such indebtedness shall commence on the effective date of the policy. Where evidence of insurability is required and such evidence is furnished more than ninety (90) days after the date when the debtor becomes obligated to the creditor, the term of the insurance may commence on the date on which the insurance company determines the debtor to be insurable, and in such event there shall be an approximate refund or adjustment on any charge to the debtor for insurance. The term of such insurance shall not extend more than thirty (30) days beyond the scheduled maturity date of the indebtedness, except when extended without additional cost to the debtor.

HISTORY: Laws, 1986, ch. 440, § 5, eff from and after May 1, 1986.

RESEARCH REFERENCES

ALR.

Initiation and termination of coverage under group credit life or disability insurance. 5 A.L.R.3d 962.

Effective date of group life insurance as to individual policies of employees. 66 A.L.R.3d 1175.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 262-281, 412, 413.

CJS.

44 C.J.S., Insurance §§ 409-412.

§ 83-53-11. Reinsurance and retrocession agreements.

An insurer licensed in the State of Mississippi may not enter into any reinsurance agreement or retrocession agreement, with another insurance company after May 1, 1986, whereby credit life or credit accident and health insurance on risks located within this state, would be ceded to an insurer which is not licensed to engage in the writing of such lines of insurance within the State of Mississippi, or which does not meet the statutory financial and other requirements for admission and licensing in this state. An insurer shall not enter into any such reinsurance or retrocession agreement with another insurance company which would by the terms and provisions thereof serve to, either directly or indirectly, circumvent this chapter or any other law of the State of Mississippi, or any regulation issued thereunder. The commissioner shall have the right to inspect, review and approve any reinsurance or retrocession agreement between insurance companies affecting any risks or insureds located in the State of Mississippi pertaining to credit life or credit disability insurance. Provided, however, any reinsurance or retrocession agreements between insurance companies in effect prior to May 1, 1986, shall be allowed to continue, but this chapter shall apply to any renewal, extension, endorsement or similar amendment of any such reinsurance or retrocession agreement.

HISTORY: Laws, 1986, ch. 440, § 6, eff from and after May 1, 1986.

RESEARCH REFERENCES

Am. Jur.

44A Am. Jur. 2d, Insurance §§ 1809-1825.

CJS.

46 C.J.S., Insurance §§ 1720-1748.

§ 83-53-13. Requirement of individual policy or certificate of insurance; contents.

(1) All credit life insurance and credit disability insurance subject to this chapter shall be evidenced by an individual policy or, in the case of group

insurance, by a certificate of insurance, which individual policy or group certificate of insurance shall be delivered to the debtor.

(2) Each individual policy or group certificate of credit life insurance or credit disability insurance or any combination thereof or both shall, in addition to other requirements of law, set forth the name of the insurer, the name or names of the debtor, the premium or amount of payment by the debtor separately for credit life insurance and credit disability insurance, a description of the coverage, including the amount and term thereof, and any exceptions, limitations and restrictions, and shall state that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness and, whenever the amount of insurance may exceed the unpaid indebtedness, that any excess shall be payable to a beneficiary, other than the creditor, named by the debtor, or his estate.

(3) Notwithstanding the provisions of subsection (2) of this section, a certificate issued where the indebtedness is a revolving loan or revolving charge account, may set forth the rate of premium or amount of payment.

HISTORY: Laws, 1986, ch. 440, § 7, eff from and after May 1, 1986.

JUDICIAL DECISIONS

1. In general.

An agent had apparent authority to issue a credit life insurance policy in excess of the master policy limits, and therefore his actions in issuing such a policy were binding on the insurance company, where the insurance company furnished the agent with blank certificates of insurance bearing the insurance company logo, the agent regularly issued policies of credit life insurance through the insurance company using these forms, and the agent had previously issued policies in excess of the master policy limits on several occasions. Malta Life Ins. Co. v. Estate of Washington, 552 So. 2d 827, 1989 Miss. LEXIS 435 (Miss. 1989).

RESEARCH REFERENCES

ALR.

Binding effects of limitations on or exclusions of coverage contained in master group policy but not in literature given individual insureds. 6 A.L.R.4th 835.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 183-206.

CJS.

44 C.J.S., Insurance §§ 384-406.

§ 83-53-15. Requirement of commissioner's approval with respect to insurance matters; judicial review.

All policies, certificates of insurance, notices of proposed insurance, applications for insurance, endorsements and riders delivered or issued for delivery in this state, and the schedules of premium rates pertaining thereto, shall be filed with the commissioner for his approval prior to use.

If after filing, the commissioner notifies the insurer that the form is disapproved, it is unlawful for the insurer to issue or use the form. In the notice the commissioner shall specify the reason for his disapproval and state that a hearing will be granted within thirty (30) days after receipt of request in writing by the insurer. No such policy, certificate of insurance, notice of proposed insurance, nor any application, endorsement or rider shall be issued or used unless and until the commissioner shall give his prior written approval thereto.

Any insurer or other party affected by any order or final determination of the commissioner under the provisions of this section may obtain judicial review thereof by filing in the Circuit Court of Hinds County within thirty (30) days from the date thereof a written petition or complaint praying that said order or final determination be modified or reversed. A copy of such petition or complaint shall be forthwith served upon the commissioner, and the commissioner shall file a transcript of the entire record of the proceedings with said court, which shall then have jurisdiction of the proceedings and questions determined therein. Said court shall have the power to make or enter a judgment modifying, affirming or reversing the order or final determination of the commissioner in whole or in part.

A premium rate or schedule of premium rates shall be deemed reasonable for all purposes under this chapter and shall be deemed approved by the commissioner upon filing with the commissioner as required by this section if the premium rate or schedule of premium rates meets the requirements for being considered reasonable under Section 83-53-23. However, a different premium rate or schedule of premium rates shall be deemed reasonable upon the filing thereof with the commissioner as required by this section if it produces, or reasonably may be expected to result in claims incurred in excess of fifty percent (50%) of earned premiums.

HISTORY: Laws, 1986, ch. 440, § 8, eff from and after May 1, 1986.

RESEARCH REFERENCES

ALR.

Validity and construction of statutes relating to style or prominence with which provisions must be printed in insurance policy. 36 A.L.R.3d 464.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 23-65.

CJS.

44 C.J.S., Insurance §§ 76-143.

§ 83-53-17. Premium rates; refunds; remission of premiums by agent; rules relative to insurer's certification of compliance with chapter.

(1) Any insurer with the prior approval of the commissioner may revise its schedules of premium rates from time to time and shall file the revised schedules with the commissioner. No insurer shall issue any credit life insurance policy or credit disability insurance policy for which the premium rate exceeds that determined by the schedules of the insurer as previously approved by the commissioner.

(2) Each individual policy or group certificate shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance

shall be paid or credited promptly by the insurer to the person entitled thereto; provided, however, that no refund of less than Two Dollars ($2.00) need be made. The formula to be used in computing the premium refund shall be the "sum of the digits" formula with respect to decreasing term credit life insurance and credit disability insurance, and the "pro rata" formula with respect to level term credit life insurance. Upon the payment of a death benefit under the credit life insurance coverage, the entire premium shall be considered earned and no refund shall be due. The insurer shall pay or cause to be paid to the debtor any refund due pursuant to this subsection within thirty (30) days of the accrual of such refund.

(3) The amount required of a debtor for any credit life or credit disability insurance shall not exceed the premium rate allowed to the insurer computed at the time the cost to the debtor is determined. All premiums payable to the insurer less any compensation to the agent or supervising general agent shall be remitted by the agent or supervising general agent to the insurer within sixty (60) days of collection.

(4) The commissioner may promulgate rules whereby an insurer may certify that the policy forms and other documents required to be approved by the commissioner prior to use are in compliance with this chapter.

HISTORY: Laws, 1986, ch. 440, § 9, eff from and after May 1, 1986.

JUDICIAL DECISIONS

ANALYSIS

1. Unearned credit life premiums.
2. Notice of claim.

1. Unearned credit life premiums.

The record suggested that defendants, a lender and an affiliated insurer, had complied with the statutory and regulatory requisites in calculating refunds of unearned premiums for property insurance under the Rule of 78ths. Smith v. Tower Loan of Miss., Inc., 216 F.R.D. 338, 2003 U.S. Dist. LEXIS 11070 (S.D. Miss. 2003), aff'd, 91 Fed. Appx. 952, 2004 U.S. App. LEXIS 4955 (5th Cir. Miss. 2004).

The statute requires an insurer, but not a creditor, to make a prompt refund of unearned credit life premiums. No Mississippi law imposes a duty on a lender to refund unearned credit life premiums upon early termination of an installment contract. Mic Life Ins. Co. v. Hicks, 2000 Miss. App. LEXIS 299 (Miss. Ct. App. June 23, 2000), aff'd in part, rev'd, 2001 Miss. LEXIS 296 (Miss. Oct. 31, 2001).

2. Notice of claim.

Credit life insurance premium added to the principal of an installment contract for the purchase of a truck resulted in the insurer holding unearned premiums after the loan was satisfied, but § 83-53-17 does not contain a notice requirement, so directed verdict for plaintiff, who was not notified of her right to a refund, could not stand. MIC Life Ins. Co. v. Hicks, 825 So. 2d 616, 2002 Miss. LEXIS 221 (Miss. 2002).

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 40-42.

CJS.

44 C.J.S., Insurance §§ 81-124.

§ 83-53-19. Reporting and settlement of claims; maintenance of claim files.

All claims shall be promptly reported by the debtor, his agent or estate to the insurer or its designated claims representative, who shall maintain adequate claim files. All claims shall be settled in accordance with the terms of the insurance contract by the insurer who shall be the sole party liable to the debtor for the payment of claims or refunds.

HISTORY: Laws, 1986, ch. 440, § 10, eff from and after May 1, 1986.

RESEARCH REFERENCES

ALR.

Validity, construction, and effect of provisions, in insurance policies allowing disability or accident benefits, which require insured to submit to physical examination. 5 A.L.R.3d 929.

Insurer's liability for consequential or punitive damages for wrongful delay or refusal to make payments due under contracts. 47 A.L.R.3d 314.

What conditions constitute "disease" within terms of life, accident, disability, or hospitalization insurance policy. 61 A.L.R.3d 822.

Libel and Slander: privileged nature of communications between insurer and insured. 85 A.L.R.3d 1161.

Doctrine of unconscionability as applied to insurance contracts. 86 A.L.R.3d 862.

What constitutes bad faith on part of insurer rendering it liable for statutory penalty imposed for bad faith failure to pay, or delay in paying, insured's claim. 33 A.L.R.4th 579.

Credit life insurer's punitive damage liability for refusing payment. 55 A.L.R.4th 246.

Am. Jur.

44 Am. Jur. 2d, Insurance §§ 1315, 1316, 1318 et seq.

CJS.

45 C.J.S., Insurance §§ 1417 et seq.

§ 83-53-21. Freedom of debtor to procure insurance from any authorized company.

When credit life insurance or credit disability insurance is required as additional security for any indebtedness, the debtor shall be free to procure the required insurance from any insurance company authorized to transact credit life insurance or credit disability insurance business in this state.

HISTORY: Laws, 1986, ch. 440, § 11, eff from and after May 6, 1986.

§ 83-53-23. Reasonable insurance rates; prohibition against additional charges.

(1) Credit life insurance rates filed with the commissioner shall be considered reasonable:

(a) If the single premium rate for single life decreasing term credit life insurance does not exceed Eighty Cents (80¢) per annum per One Hundred Dollars ($100.00) of initial insured indebtedness;

(b) If the single premium rate for single life level term credit life insurance does not exceed a single premium rate of One Dollar and Sixty

Cents ($1.60) per annum per One Hundred Dollars ($100.00) of insured indebtedness;

(c) If the monthly premium rate on single life credit life insurance on outstanding balances does not exceed a monthly premium of One Dollar and Thirty-three Cents ($1.33) per One Thousand Dollars ($1,000.00) of outstanding indebtedness;

(d) If the single premium rate for joint life decreasing term credit life insurance does not exceed One Dollar and Thirty-nine Cents ($1.39) per annum per One Hundred Dollars ($100.00) of initial insured indebtedness;

(e) If the single premium rate for joint life level term credit life insurance does not exceed Two Dollars and Eighty ($2.80) per annum per One Hundred Dollars ($100.00) of insured indebtedness;

(f) If a monthly premium rate on joint life credit life insurance on outstanding balances does not exceed a monthly premium of Two Dollars and Thirty-four Cents ($2.34) per One Thousand Dollars ($1,000.00) of outstanding indebtedness;

(g) If the amount is a minimum premium not exceeding Two Dollars ($2.00).

(2) The foregoing life insurance rates are considered reasonable in relation to the benefits only if:

(a) The credit life insurance coverage must contain a suicide exclusion provision wherein no benefit shall be paid in case of suicide within the first twelve (12) months after the effective date of the coverage.

(b) Coverage is provided or offered to all debtors regardless of age, or to all debtors not older than the applicable age limit, which shall not be less than the attained age of sixty-five (65) years, if the limit applies to the age when the insurance attaches, or not less than attained the age of sixty-six (66) years if the limit applies to the age on the scheduled maturity date of the debt. Such aforementioned requirements provided by this subsection shall not prevent the usage of equitable underwriting standards to determine the eligibility of individual debtors as to a part or all of the coverage provided by the credit life insurance contract. Age and term limits, wherein the amount of insurance provided or offered varies by age, if used, must be clearly shown on the individual policies or group certificates.

(3) The following credit disability insurance premium rates filed with the commissioner shall be considered reasonable in relation to the benefits if the single premium rate for credit disability insurance does not exceed the premium rates shown in the following schedule per One Hundred Dollars ($100.00) of initial insured indebtedness.

NO. OF MONTHS IN WHICH INDEBTEDNESS IS PAYABLE	NONRETROACTIVE BENEFITS		RETROACTIVE BENEFITS	
	14-DAY NONRETROACTIVE	30-DAY NONRETROACTIVE	14-DAY RETROACTIVE	30-DAY RETROACTIVE
1-12	2.50	2.10	3.00	2.85
13-24	3.30	2.90	3.80	3.65
25-36	4.10	3.70	4.60	4.45
37-48	4.90	4.50	5.40	5.25
49-60	5.70	5.30	6.20	6.05
61-72	6.10	5.70	6.60	6.45
73-84	6.50	6.10	7.00	6.85
85-96	6.90	6.50	7.40	7.25
97-108	7.30	6.90	7.80	7.65
109-120	7.70	7.30	8.20	8.05

Premiums payable other than on a single premium basis or for benefits on a basis different than illustrated above shall be actuarially consistent with the above rates.

(4) The foregoing disability rates are considered to produce reasonable benefits in relation to premiums only if:

(a) Coverage may be provided or offered to all debtors, who are gainfully employed on the effective date of insurance and who are not older than the applicable age limit, which shall not be less than the attained age of sixty-five (65) years, if the limit applies to the age when the insurance attaches, or not less than the attained age of sixty-six (66) years if the limit applies to the age on the scheduled maturity date of the debt. Such aforementioned requirements provided by this subsection shall not prevent the usage of equitable underwriting standards to determine the eligibility of individual debtors as to a part or all of the coverage provided by the disability insurance contract. Age and term limits, wherein the amount of insurance or term provided or offered varies by age, if used, must be clearly shown on the individual policies or group certificates;

(b) Coverage does not contain any exclusions except disabilities resulting from intentional self-inflicted injury, pregnancy, foreign residence, flights in nonscheduled aircraft and preexisting illness, disease or physical condition for which the debtor either: (i) knew the existence of such illness, disease or condition on the effective date, or (ii) received medical advice, consultation or treatment during the twelve-month period immediately preceding the effective date of the debtor's coverage.

(5) An insurer may receive approval of a different premium rate or schedule of premium rates to be used in connection with a particular policy form, or any type of coverage other than described herein, or a particular class or classes of risk of the debtors of a creditor, if the insurer demonstrates to the satisfaction of the commissioner that the mortality or morbidity experience

which may reasonably be anticipated will develop a loss ratio in excess of fifty percent (50%).

(6) No certificate fee, policy issue charge, or any other charge other than the premium herein shall be made.

HISTORY: Laws, 1986, ch. 440, § 12, eff from and after July 1, 1987.

Cross References — Provision that premium rates shall be deemed approved by the commissioner upon filing if they meet the reasonableness requirements of this section, see § 83-53-15.

JUDICIAL DECISIONS

1. In general.

Defendant lender was required to and did conduct its business pursuant to applicable statutes and regulations and, accordingly, was protected by law when it complied with these statutes and regulations; the borrowers affirmatively represented the value of the personal property to the lender in their promissory notes and security agreements so their allegations of excessive rates, or challenges of the "rates and terms" of the governmentally-approved insurance contracts, were barred by the filed rate doctrine. Smith v. Tower Loan of Miss., Inc., 216 F.R.D. 338, 2003 U.S. Dist. LEXIS 11070 (S.D. Miss. 2003), aff'd, 91 Fed. Appx. 952, 2004 U.S. App. LEXIS 4955 (5th Cir. Miss. 2004).

Though a credit disability insurer had an arguable basis for denying the insured's claim, since his disabling condition had been preexisting, as the jury could have concluded that the insurer acted with gross negligence or reckless disregard for the insured's rights, the trial court erred by granting the insurer judgment notwithstanding the verdict on a punitive damages award. Stewart v. Gulf Guar. Life Ins. Co., 846 So. 2d 192, 2002 Miss. LEXIS 254 (Miss. 2002).

Regulation adopted by Insurance Commissioner, requiring credit life insurers to substantiate loss ratio of 50% "at all ages (i.e., each age band)" before charging rates exceeding statutory rate, was inconsistent with statute allowing rate variance to be granted when loss ratio for particular class is at least 50%; accordingly, regulation was outside scope of Commissioner's power to promulgate. American Federated Life Ins. Co. v. Dale, 701 So. 2d 809, 1997 Miss. LEXIS 625 (Miss. 1997).

RESEARCH REFERENCES

ALR.

What constitutes "serious illness," "serious disease," or equivalent language used in insurance application. 28 A.L.R.3d 1255.

Time when period provided for in suicide clause of life or accident policy begins to run. 37 A.L.R.3d 933.

Am. Jur.

44 Am. Jur. 2d, Insurance §§ 819-931.

CJS.

44 C.J.S., Insurance §§ 545-615.

§ 83-53-25. Limitation upon compensation in connection with insurance contract.

(1) No one shall pay, accrue, credit or otherwise allow, either directly or indirectly, any compensation to any creditor, person, partnership, corporation, association or other entity in connection with any policy, certificate or other contract of credit life insurance or credit disability insurance which exceeds

forty-five percent (45%) of the premium rates approved for such policy, certificate or contract.

(2) "Compensation," as used herein, shall include, but not be limited to, all of the following:

(a) Commission, fees and expense allowances;

(b) The fair market value of all equipment, calculators, goods and services;

(c) The fair market value of benefits such as travel, vacations or other rewards of any kind; and

(d) All other accruals, payments and other compensation or expenditures in any form whatsoever.

(3) "Compensation" shall not include:

(a) Bona fide corporate dividends paid or accrued by an insurance company to a stockholder;

(b) Bona fide compensation paid to or reimbursement of expenses incurred by a director, officer or employee of an insurance company for the performance of the corporate duties of any such director, officer or employee;

(c) Experience refunds paid, allocated or accrued by an insurer pursuant to a written experience refund agreement which are paid only with respect to earned premiums produced by or attributable to the creditor or licensed agent designated to receive such experience refund; provided, however, that:

(i) All such experience refund agreements shall be on a form approved in writing by the commissioner;

(ii) All such experience refunds shall be calculated using only accounting methods approved by the commissioner;

(iii) All such experience refund calculations shall be made in accordance with the requirements of a form prescribed by the commissioner which form shall provide, among other things, for the deduction of claims incurred, premium taxes earned, compensation paid or earned and expenses incurred during the preceding calendar year, all of which shall be determined in a manner acceptable to the commissioner; and

(iv) All such experience refunds shall be paid annually within thirty (30) days following the filing of the insurer's annual statement with the Department of Insurance;

(d) Corporate allocations or dividends paid, allocated or accrued by an insurer or insurance holding company from any part of the assets, income, earnings, profits or losses of any corporation, insurer or other legal entity with respect to any class or series of stock, or other equity interest, in the insurer or insurance holding company, including payments for the redemption or purchase by the issuer of such shares or other equity interest.

(4) The commissioner is hereby vested with full authority as provided by Section 83-53-29 to regulate, reduce and/or adjust experience refunds or corporate allocations in accordance with the provisions of paragraphs (c) and (d) of subsection (3) of this section.

HISTORY: Laws, 1986, ch. 440, § 13; Laws, 1989, ch. 492, § 1; Laws, 2014, ch. 389, § 1, eff from and after July 1, 2014.

Cross References — Additional compensation payable to credit life/credit disability supervising general agent, see § 83-53-27.

RESEARCH REFERENCES

Am. Jur.	**CJS.**
43 Am. Jur. 2d, Insurance §§ 171-182.	44 C.J.S., Insurance §§ 198-253.

§ 83-53-27. Additional compensation payable to credit life/credit disability supervising general agent; functions and duties of supervising general agents.

(1) Notwithstanding any provision in Section 83-53-25 to the contrary, an insurer may pay, in addition to the compensation authorized by Section 83-53-25, an overriding commission to a credit life/credit disability supervising general agent. A supervising general agent shall be responsible for and supervise soliciting agents and no soliciting agent under the supervision of the supervising general agent may be either directly or indirectly an employee of a supervising general agent. Furthermore, no supervising general agent shall have any monetary interest in the creditor with whom the soliciting agent is affiliated for the writing of such insurance in any way or exercise any control over such business operation either directly or indirectly. A supervising general agent is defined as an individual or entity which performs the following documented functions:

(a) Provides administrative services for insurance companies in the hiring, training and supervision of all agents under the supervising general agent's authority;

(b) Provides underwriting services on behalf of the insurance company;

(c) Audits reports submitted by the soliciting agent;

(d) Requires compliance of all statutory responsibilities of soliciting agents under the supervising general agent's authority. Any supervising general agent who has knowledge of statutory violations by soliciting agents under such agent's supervision or responsibility may be subject to disciplinary action by the Insurance Department for the activities of that soliciting agent or agency.

(2) Documentation of the above responsibilities will include the following and must be retained by the supervising general agent for three (3) years:

(a) Written records certifying compliance of all hiring, training and monthly reports verifying continuous supervision of the soliciting agents' activities;

(b) Complete records certifying underwriting review of policies and group contracts.

(3) Supervising general agents may not receive directly or indirectly any soliciting agents' commissions nor pay any portion of such overriding commission to any creditor or other agent.

HISTORY: Laws, 1986, ch. 440, § 14; Laws, 1989, ch. 492, § 2, eff from and after July 1, 1989.

RESEARCH REFERENCES

ALR.
Insurance agent's right to commissions on renewal premiums. 36 A.L.R.3d 958.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 171-182.

CJS.
44 C.J.S., Insurance §§ 198-253.

§ 83-53-29. Promulgation of rules and regulations; requirement of information.

The commissioner may, after notice and hearing, issue any rules and regulations that he deems necessary to effectuate the purposes of this chapter or to eliminate devices or plans designed to avoid or render ineffective the provisions of this chapter. The commissioner may require such information as is reasonably necessary for the enforcement of this chapter. All rules and regulations adopted and promulgated pursuant to this chapter shall be subject to the Mississippi Administrative Procedures Law.

HISTORY: Laws, 1986, ch. 440, § 15, eff from and after May 6, 1986.

Cross References — Mississippi Administrative Procedures Law, see §§ 25-43-1.101 et seq.

Authority of commissioner to regulate experience refunds or corporate allocations, see § 83-53-25.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 23-65.

CJS.
44 C.J.S., Insurance §§ 76-143.

§ 83-53-31. Issuance of cease and desist order; penalties.

Whenever there has been a violation of this chapter or any rule or regulation issued pursuant thereto, the commissioner shall issue and serve upon the insurer, agent or other person charged with such violation an order requiring such person to cease and desist from violating this chapter or any rule or regulation issued pursuant thereto.

In addition, the commissioner, in the cease and desist order, may impose upon such person a fine not to exceed One Thousand Dollars ($1,000.00) for each violation and may revoke, suspend or decline to renew any license of such person to sell or issue insurance.

HISTORY: Laws, 1986, ch. 440, § 16, eff from and after May 1, 1986.

Cross References — Hearings with respect to cease and desist orders issued under this section, see § 83-53-33.

When orders of the commissioner become effective, see § 83-53-39.

RESEARCH REFERENCES

ALR.
Credit life insurer's punitive damage liability for refusing payment. 55 A.L.R.4th 246.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 23-65.

CJS.
44 C.J.S., Insurance §§ 76-143.

§ 83-53-33. Hearing relative to cease and desist order; costs; service of process.

Any person affected by a cease and desist order issued under Section 83-53-31 may, within thirty (30) days after being served with such cease and desist order, petition the commissioner for a hearing to consider the alleged violation of this chapter or any rule or regulation issued pursuant thereto. The commissioner shall set the time and place of such hearing, which shall not be less than ten (10) days nor more than thirty (30) days after the date the petition is received by the commissioner.

At the time and place fixed for such hearing, such person shall have an opportunity to be heard and to show cause why the order of the commissioner requiring such person to cease and desist from the violation or violations complained of should not be made final.

Upon good cause shown, the commissioner shall permit any person to intervene, appear and be heard at such hearing by counsel or in person.

Nothing contained herein shall require the observance at any such hearing of formal rules of pleadings or evidence.

The commissioner, upon such hearing, may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence, and shall have the power to subpoena witnesses, compel their attendance and require the production of books, papers, records, correspondence or other documents which he deems relevant to the inquiry. The commissioner, upon such hearing, may, and upon the request of any party shall, cause to be made a stenographic record of all the evidence and all the proceeding had at such hearing. If no stenographic record is made and if a judicial review is sought, the commissioner shall prepare a statement of the evidence and proceeding for use on review. In case of a refusal of any person to comply with any subpoena issued hereunder or to testify with respect to any matter concerning which he may be lawfully interrogated, the Circuit Court of Hinds County, on application of the commissioner, may issue an order requiring such person to comply with such subpoena and to testify; and any failure to obey any such order of the court may be punished by the court as a contempt thereof.

The commissioner by regulation shall provide for the assessment of, costs for stenographic records, process and other related expenses pertaining to proceedings pursuant to this section, and may require a deposit or other security therefor.

Statements of charges, notices, orders and other processes of the commissioner may be served by anyone duly authorized by the commissioner, either in the manner provided by law for service of process in civil actions or by registering and mailing a copy thereof to the person affected by such statement, notice, order or other process at his or its residence or principal office or place of business. The verified return by the person so serving such statement, notice, order or other process, setting forth the manner of such service, shall be proof of the same; and the return postcard receipt for such statement, notice, order or other process, registered and mailed as aforesaid, shall be proof of the service of the same.

HISTORY: Laws, 1986, ch. 440, § 17, eff from and after May 6, 1986.

Cross References — When orders of the commissioner become effective, see § 83-53-39.

Provision that a hearing shall be held within thirty days after the petition for the hearing is filed, see § 83-53-45.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance §§ 23-65.	44 C.J.S., Insurance §§ 76-143.

§ 83-53-35. Order, after hearing, as to findings, conclusions, and decision.

After such hearing the commissioner shall issue and cause to be served upon the person charged with the violation and any petitioner or intervenor an order setting forth the commissioner's findings, conclusions and decision.

HISTORY: Laws, 1986, ch. 440, § 18, eff from and after May 6, 1986.

Cross References — Judicial review of an order issued under this section, see § 83-53-37.

When orders of the commissioner become effective, see § 83-53-39.

Appeal from an order under this section which does not charge a violation, see § 83-53-41.

Provision that a hearing shall be held within thirty days after the petition for the hearing is filed, see § 83-53-45.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance §§ 23-65.	44 C.J.S., Insurance §§ 76-143.

§ 83-53-37. Judicial review.

Any person affected by an order of the commissioner under Section 83-53-35 may obtain a review of such order by filing in the Circuit Court of Hinds County, within thirty (30) days from the date of the service of such order, a complaint praying that the order of the commissioner be modified or set aside. A copy of such petition or complaint shall be forthwith served upon the commissioner, and thereupon the commissioner forthwith shall certify and file in such court a transcript of the entire record in the proceeding, including all the evidence taken and the findings and order of the commissioner. Upon such filing of the petition and transcript, such court shall have jurisdiction of the proceedings and of the question determined therein, shall determine whether the filing of such petition shall operate as a stay of such order of the commissioner, and shall have power to make and enter upon the pleadings, evidence and proceedings set forth in such transcript a judgment modifying, affirming or reversing the order of the commissioner, in whole or in part. Any party, including the commissioner, aggrieved by a final decision of said circuit court, may appeal to the Supreme Court in the manner provided by law.

HISTORY: Laws, 1986, ch. 440, § 19, eff from and after May 1, 1986.

Cross References — Provision that a hearing shall be held within thirty days after the petition for the hearing is filed, see § 83-53-45.

RESEARCH REFERENCES

ALR.
Credit life insurer's punitive damage liability for refusing payment. 55 A.L.R.4th 246.

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 23-65.

CJS.
44 C.J.S., Insurance §§ 76-143.

§ 83-53-39. Effective dates of orders; stay of execution or enforcement.

A cease and desist order issued by the commissioner under Section 83-53-31 shall become final upon the completion of the time allowed for filing a petition with the commissioner for a hearing if no such petition has been duly filed within such time. If a petition for a hearing is filed within such time pursuant to Section 83-53-33, the order of the commissioner shall not take effect and be in force until the issuance of an order pursuant to Section 83-53-35. An order issued pursuant to Section 83-53-35 shall take effect and be in force upon issuance or at such time as may be stated in such order. The commissioner, in his discretion, or the circuit court, upon appeal, may stay the execution or enforcement of any such order.

HISTORY: Laws, 1986, ch. 440, § 20, eff from and after May 6, 1986.

Cross References — Provision that a hearing shall be held within thirty days after the petition for the hearing is filed, see § 83-53-45.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 23-65.

CJS.
44 C.J.S., Insurance §§ 76-143.

§ 83-53-41. Appeal from order which does not charge violation.

If the order of the commissioner under Section 83-53-35 does not charge a violation of this chapter or any rule or regulation pursuant thereto, then any petitioner or intervenor in the proceedings may, within thirty (30) days after the service of such report, file a petition or complaint in the Circuit Court of Hinds County for a review of such order. Upon such review, the court shall have the authority to issue appropriate orders and decrees in connection therewith, including orders enjoining and restraining the continuance of any act which it finds, notwithstanding such order of the commissioner, constitutes a violation of this chapter or any rule or regulation issued pursuant thereto.

HISTORY: Laws, 1986, ch. 440, § 21, eff from and after May 1, 1986.

Cross References — Provision that a hearing shall be held within thirty days after the petition for the hearing is filed, see § 83-53-45.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance §§ 23-65.	44 C.J.S., Insurance §§ 76-143.

§ 83-53-43. Penalty for violation of final order; civil action to recover penalty.

Any person who violates an order of the commissioner, after it has become final, and while such order is in effect, shall, upon proof thereof to the satisfaction of the court, forfeit and pay to the State of Mississippi a sum to be determined by the commissioner not to exceed Five Thousand Dollars ($5,000.00) for each violation, which if not paid may be recovered in a civil action instituted in the name of the commissioner in the circuit court in the county of the residence of such person who is a resident of the state. In the case of a nonresident, the action shall be brought in the Circuit Court of Hinds County.

HISTORY: Laws, 1986, ch. 440, § 22, eff from and after May 6, 1986.

Cross References — Provision that a hearing shall be held within thirty days after the petition for the hearing is filed, see § 83-53-45.

RESEARCH REFERENCES

Am. Jur.	CJS.
43 Am. Jur. 2d, Insurance §§ 23-65.	44 C.J.S., Insurance §§ 76-143.

§ 83-53-45. Time for hearing.

Whenever any insurer, agent or other interested party petitions the commissioner for a hearing to consider any alleged violation of this chapter or any rule or regulation issued pursuant thereto, the commissioner shall hold a hearing within thirty (30) days after the petition is filed with the commissioner and proceed as provided in Sections 83-53-33 through 83-53-43.

HISTORY: Laws, 1986, ch. 440, § 23, eff from and after May 6, 1986.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 23-65.

CJS.
44 C.J.S., Insurance §§ 76-143.

§ 83-53-47. Relation to other laws.

Nothing in this chapter shall be construed to relieve any person from compliance with any other applicable law of this state.

HISTORY: Laws, 1986, ch. 440, § 24, eff from and after May 6, 1986.

CHAPTER 54.

MISSISSIPPI CREDITOR-PLACED INSURANCE ACT

Sec.

83-54-1. Purpose of chapter.
83-54-3. Application and construction of chapter.
83-54-5. Definitions.
83-54-7. Effective date and termination date of coverage.
83-54-9. Insurance premiums.
83-54-11. Exclusions from coverage.
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83-54-15. Policy forms, certificates of insurance, and schedules of premium rates to be filed with Commissioner of Insurance; disapproval of forms or schedules; schedules not to be excessive, inadequate, or unfairly discriminatory; withdrawal of approval of approved forms or schedules; approved forms and schedules deemed to be in compliance with laws of the state.
83-54-17. Insurer to refund unearned premiums within 60 days after termination of coverage; statement of refund provided to debtor.
83-54-19. Payment by insurer in the event of loss.
83-54-21. Prerequisites for creditor to insure collateral; right of debtor to insure collateral.
83-54-23. Entire amount of premium due shall be remitted to insurer in accordance with insurer's requirements; creditor prohibited from retaining unearned premiums upon cancellation without crediting debtor's account; rebates to creditor prohibited.
83-54-25. Creditor to make adequate disclosure to debtor of insurance requirement; "adequate disclosure" defined; when creditor may impose charges; "reasonable efforts" to notify debtor; form of notice; evidence of insurance coverage; creditor not required to insure collateral.
83-54-27. Commissioner of Insurance authorized to conduct investigations of insurers and producers, to deny, suspend, or revoke certificates of authority or producer's licenses, and to impose civil penalties; judicial review of commissioner's orders.
83-54-29. Rules and regulations.
83-54-31. Severability.

§ 83-54-1. Purpose of chapter.

The purposes of this chapter are to:

(a) Promote the public welfare by regulating creditor-placed insurance;

(b) Create a legal framework within which creditor-placed insurance may be written in this state;

(c) Help maintain the separation between creditors and insurers; and

(d) Minimize the possibilities of unfair competitive practices in the sale of creditor-placed insurance.

HISTORY: Laws, 2001, ch. 307, § 1, eff from and after July 1, 2001.

Cross References — Credit life and credit disability insurance, see §§ 83-53-1 et seq.

§ 83-54-3. Application and construction of chapter.

(1) This chapter applies to an insurer or producer transacting creditor-placed insurance as defined in this chapter.

(2) All creditor-placed insurance written in connection with credit transactions for personal, family or household purposes is subject to the provisions of this chapter, except:

(a) Transactions involving extensions of credit primarily for business or commercial purposes;

(b) Insurance on collateralized real property; provided, however, that creditor-placed insurance written for mobile homes or manufactured housing shall be subject to the provisions of this chapter;

(c) Insurance offered by the creditor and elected by the debtor at the debtor's option;

(d) Insurance for which no specific charge is made to the debtor or the debtor's account; or

(e) Blanket insurance, whether paid for by the debtor or the creditor.

(3) Nothing in this chapter shall be construed to create or imply a private cause of action for violation of this chapter, and the commissioner shall have authority to bring administrative or judicial proceedings to enforce this chapter.

HISTORY: Laws, 2001, ch. 307, § 2, eff from and after July 1, 2001.

§ 83-54-5. Definitions.

As used in this chapter, unless the context otherwise requires:

(a) "Actual cash value (ACV)" means the cost of replacing damaged or destroyed property with comparable new property, minus depreciation and obsolescence.

(b) "Blanket insurance" means insurance that provides coverage on collateral as defined in a policy issued to a creditor, without specifically listing the collateral covered.

(c) "Collateral" means personal property that is pledged as security for the satisfaction of a debt.

(d) "Credit agreement" means the written document that sets forth the terms of the credit transaction and includes the security agreement.

(e) "Credit transaction" means a transaction by the terms of which the repayment of money loaned or credit commitment made, or payment of goods, services or properties sold or leased, is to be made at a future date or dates.

(f) "Creditor" means the lender of money or vendor or lessor of goods, services, property, rights or privileges for which payment is arranged through a credit transaction, or any successor to the right, title or interest of a lender, vendor or lessor.

(g) "Creditor-placed insurance" means insurance that is purchased unilaterally by the creditor, who is the named insured, subsequent to the date of the credit transaction, providing coverage against loss, expense or damage to collateralized personal property as a result of fire, theft, collision or other risks of loss that would either impair a creditor's interest or adversely affect the value of collateral covered by limited dual interest insurance. It is purchased according to the terms of the credit agreement as a result of the debtor's failure to provide required physical damage insurance, with the cost of the coverage being charged to the debtor. It shall be either single interest insurance or limited dual interest insurance.

(h) "Debtor" means the borrower of money or a purchaser or lessee of goods, services, property, rights or privileges for which payment is arranged through a credit transaction.

(i) "Insurance tracking" means monitoring evidence of insurance on collateralized credit transactions to determine whether insurance required by the credit agreement has lapsed, and communicating with debtors concerning the status of insurance coverage.

(j) "Insurer" means an insurance company, association or exchange authorized to issue insurance policies in the State of Mississippi.

(k) "Lapse" means that the insurance coverage required by the credit agreement is not in force.

(*l*) "Limited dual interest insurance" means insurance purchased by the creditor to insure its interest in the collateral securing the debtor's credit transaction. This insurance waives the three (3) conditions for loss payment under single interest insurance and extends coverage on the collateral while in the possession of the debtor.

(m) "Loss ratio" means the ratio of incurred losses to earned premium.

(n) "Net debt" means the amount necessary to liquidate the remaining debt in a single lump-sum payment, excluding all unearned interest and other unearned charges.

(o) "Producer" means a person who receives a commission for insurance placed or written or who, on behalf of an insurer or creditor, solicits, negotiates, effects, procures, delivers, renews, continues or binds policies of insurance to which this chapter applies, except a regular salaried officer, employee or other representative of an insurer who devotes substantially all working time to activities other than those specified here and who receives no compensation that is directly dependent on the amount of insurance business written, and except a regular salaried officer or employee of a creditor who receives no compensation that is directly dependent on the amount of insurance effected or procured.

(p) "Single interest insurance" means insurance purchased by the creditor to insure its interest in the collateral securing a debtor's credit transaction. Three (3) conditions must be met for payment of loss under the policy:

(i) The debtor has defaulted in payment;

(ii) The creditor has legally repossessed the collateral, unless collateral has been stolen from the debtor; and

(iii) The creditor has suffered an impairment of interest.

(q) "Commissioner" means the Commissioner of Insurance.

HISTORY: Laws, 2001, ch. 307, § 3, eff from and after July 1, 2001.

§ 83-54-7. Effective date and termination date of coverage.

(1) Creditor-placed insurance shall become effective on the latest of the following dates:

(a) The date of the credit transaction;

(b) The date prior coverage, including prior creditor-placed insurance coverage lapsed;

(c) One (1) year before the date on which the related insurance charge is made to the debtor's account; or

(d) A later date provided for in the agreement between the creditor and insurer.

(2) Creditor-placed insurance shall terminate on the earliest of the following dates:

(a) The date other acceptable insurance becomes effective, subject to the debtor providing acceptable evidence of the other insurance to the creditor;

(b) The date the collateralized personal property is repossessed, unless the property is returned to the debtor within ten (10) days of the repossession. The creditor-placed insurance may be kept in force, but the lender must pay the premium that is earned after repossession;

(c) The date the collateralized personal property is determined by the insurer to be a total loss;

(d) The date the debt is completely extinguished; or

(e) An earlier date specified in the individual policy or certificate of insurance.

(3) An insurance charge shall not be made to a debtor for a term longer than the scheduled term of the creditor-placed insurance when it becomes effective, nor may an insurance charge be made to the debtor for creditor-placed insurance before the effective date of the insurance.

(4) If a charge is made to a debtor for creditor-placed insurance coverage that exceeds a term of one (1) year, the debtor shall be notified at least annually that the insurance will be canceled and a refund or credit of unearned charges made if evidence of acceptable insurance secured by the debtor is provided.

HISTORY: Laws, 2001, ch. 307, § 4, eff from and after July 1, 2001.

Cross References — Statement of refund not required if policy terminates pursuant to subsection (2) of this section, see § 83-54-17.

§ 83-54-9. Insurance premiums.

(1) Premiums for creditor-placed insurance coverage may be calculated based on:

(a) An amount not exceeding the net debt even though the coverage may limit the insurer's liability to the net debt, actual cash value or cost of repair; or

(b) Other premium calculation methods that more closely reflect the exposure of each item insured and approximate the premium calculation method of the coverage required by the credit agreement.

(2) An insurer shall not write creditor-placed insurance for which the premium rate differs from that determined by the schedules of the insurer on file and approved by the commissioner. The premium or amount charged to the debtor for creditor-placed insurance shall not exceed the premiums charged by the insurer, computed at the time the charge to the debtor is determined.

(3) A method of billing insurance charges to the debtor on closed-end credit transactions that creates a balloon payment at the end of the credit transaction or extends the credit transaction's maturity date is prohibited, unless specifically disclosed at the time of the origination of the credit agreement.

HISTORY: Laws, 2001, ch. 307, § 5, eff from and after July 1, 2001.

§ 83-54-11. Exclusions from coverage.

(1) Creditor-placed insurance coverage shall not include:

(a) Coverage for the cost of repossession;

(b) Skip, confiscation and conversion coverage;

(c) Coverage for payment of mechanics' or other liens that do not arise from a covered loss occurrence;

(d) Coverage that requires a debtor's insurance deductible to be less than Two Hundred Dollars ($200.00); or

(e) Coverage that is broader than the insurance coverages that meet the minimum insurance requirements of the credit agreement.

(2) Nothing in this section shall be deemed to prohibit the issuance of a separate policy or endorsement providing the coverages listed in subsection (1) of this section. However, no charge shall be passed along to the debtor for the coverages.

HISTORY: Laws, 2001, ch. 307, § 6, eff from and after July 1, 2001.

§ 83-54-13. Evidence of insurance coverage.

Creditor-placed insurance shall be set forth in an individual policy or certificate of insurance. A copy of the individual policy, certificate of insurance coverage or other evidence of insurance coverage shall be mailed, first-class mail, or delivered in person to the last known address of the debtor.

HISTORY: Laws, 2001, ch. 307, § 7, eff from and after July 1, 2001.

§ 83-54-15. Policy forms, certificates of insurance, and schedules of premium rates to be filed with Commissioner of Insurance; disapproval of forms or schedules; schedules not to be excessive, inadequate, or unfairly discriminatory; withdrawal of approval of approved forms or schedules; approved forms and schedules deemed to be in compliance with laws of the state.

(1) All policy forms and certificates of creditor-placed insurance to be delivered or issued for delivery in this state and the schedules of premium rates pertaining thereto shall be filed with the Commissioner of Insurance.

(2) The commissioner shall within thirty (30) days after the filing of the policy forms and certificates of insurance disapprove a form that does not conform to this chapter or to other applicable provisions of the insurance statutes and regulations and shall, within thirty (30) days of filing, disapprove a schedule of premium rates pertaining to the form if it does not conform to the standard set forth in subsection (5).

(3) If the commissioner disapproves a form or schedule of premium rates in accordance with subsection (2), the commissioner shall promptly notify the insurer in writing of the disapproval, and it shall be unlawful for the insurer to issue or use the form or schedule. In the notice, the commissioner shall specify the reasons for disapproval and state that a hearing will be granted within sixty (60) days after receipt of request in writing by the insurer.

(4) Unless the commissioner disapproves the form or schedule of premium rates in accordance with subsections (2) and (3) or gives written approval of the form or schedule within thirty (30) days after the filing, the form or schedule shall be deemed approved on the thirty-first day after the filing. However, within thirty (30) days after receiving a filing, the commissioner may issue a notice which delays the effective date of a filing for not more than thirty (30) days after the notice is issued if the commissioner determines that additional information or clarification concerning the rate or policy form is required.

(5) The schedules of premium rates shall not be excessive, inadequate or unfairly discriminatory. In determining whether a schedule of premium rates are excessive, inadequate or unfairly discriminatory, the commissioner shall take into account past and prospective loss experience, general and administrative expenses, loss settlement and adjustment expenses, reasonable creditor compensation and other acquisition costs including insurance tracking costs, reserves, taxes, licenses, fees and assessments, reasonable insurer profit and other relevant data. Rates are not unfairly discriminatory because different premiums result for different policyholders, including group policyholders, with similar loss exposures but different expense factors or similar expense factors but different loss exposures, nor are rates unfairly discriminatory if they are averaged broadly among all persons insured in this state or all persons insured under a group insurance policy.

(6) The commissioner may withdraw approval of an approved form or schedule of premium rates when the commissioner would be required to

disapprove the form or schedule of premium rates if it were filed at the time of the withdrawal. The withdrawal shall be in writing and shall specify the reasons for withdrawal and the effective date of the withdrawal. An insurer adversely affected by a withdrawal may, within thirty (30) days after receiving the written notification of the withdrawal, request in writing a hearing to determine whether the withdrawal should be annulled, modified or confirmed. Unless the commissioner grants an extension in writing in the withdrawal or subsequently grants an extension the withdrawal shall, in the absence of a request for hearing, become effective, prospectively and not retroactively, on the ninety-first day following delivery of the notice of withdrawal and, if the request for hearing is filed, on the ninety-first day following delivery of written notice of the commissioner's determination.

(7) Forms and rates filed and approved in accordance with this section shall be deemed to be in compliance in all respects with the laws of this state.

HISTORY: Laws, 2001, ch. 307, § 8, eff from and after July 1, 2001.

§ 83-54-17. Insurer to refund unearned premiums within 60 days after termination of coverage; statement of refund provided to debtor.

(1) Within sixty (60) calendar days after the termination of creditor-placed insurance coverage, and in accordance with the formulas approved by the commissioner, an insurer shall refund any unearned premium or other identifiable charges.

(2) Within sixty (60) calendar days after the termination date of creditor-placed insurance coverage, the insurer or creditor shall provide to the debtor a statement of refund disclosing the effective date, the termination date, the amount of premium being refunded and the amount of premium charged for the coverage provided. No statement shall be required in the event that the policy terminates pursuant to Section 83-54-7(2)(d).

(3) The entire amount of premiums, minimum premiums, fees or charges of any kind shall be refunded if no coverage was provided.

HISTORY: Laws, 2001, ch. 307, § 9, eff from and after July 1, 2001.

§ 83-54-19. Payment by insurer in the event of loss.

(1) In the event of a loss under the creditor-placed insurance policy, the insurer shall pay, at a minimum, the least of the following, the value of which shall be determined as of the date of loss and shall be reduced by any payments to the creditor or debtor recovered from a third party:

(a) The cost to repair the collateral, less any applicable deductible;

(b) The actual cash value of the collateral, less any applicable deductible;

(c) The net debt, less any applicable deductible; or

(d) If single interest insurance is provided, the amount by which the creditor's interest is impaired.

(2) The net debt or actual cash value amounts in subsection (1) may be reduced by the value of salvage if the insurer does not take possession of the insured property. This does not preclude the borrower's right to retain possession of the damaged collateral, if desired.

(3) In the event of a loss, no subrogation shall run against the debtor from the insurer.

(4) Whenever a claim is made on a creditor-placed insurance policy, the insurer shall furnish to the creditor a written statement of the loss explaining the settlement amount and the method of settlement, and the creditor shall furnish this information to the debtor.

(5) A creditor or insurer may not abandon salvage to a towing or storage facility in lieu of payment of storage fees without the consent of the facility and the claimant. The insurer shall be responsible for the payment of towing and storage charges for a covered loss occurrence from the time the claim is reported to the insurer in accordance with the terms of the policy to the time the claim is paid. After the claim is paid, the debtor shall be responsible for the payment of any towing or storage charges.

HISTORY: Laws, 2001, ch. 307, § 10; Laws, 2005, ch. 311, § 1, eff from and after July 1, 2005.

§ 83-54-21. Prerequisites for creditor to insure collateral; right of debtor to insure collateral.

(1) In order for the creditor to place insurance on the collateral pledged by the debtor and pass the cost of the insurance on to the debtor:

(a) The creditor must have a security interest in the personal property;

(b) The credit agreement must require the debtor to maintain insurance on the collateral to protect the creditor's interest;

(c) The credit agreement must authorize the creditor to place the insurance if the debtor fails to provide evidence of the insurance; and

(d) The information set forth in paragraphs (a) through (c) of this subsection (1) must be clearly disclosed to the debtor at the inception of the credit transaction.

(2) The debtor shall always have the right to provide required insurance through existing policies of insurance owned or controlled by the debtor or of procuring and furnishing the required coverage through an insurer authorized to transact insurance within this state. However, a creditor may establish maximum acceptable deductibles, insurer solidity standards and other reasonable conditions with respect to the required insurance.

HISTORY: Laws, 2001, ch. 307, § 11, eff from and after July 1, 2001.

§ 83-54-23. Entire amount of premium due shall be remitted to insurer in accordance with insurer's requirements; creditor prohibited from retaining unearned premiums upon cancellation without crediting debtor's account; rebates to creditor prohibited.

(1) The entire amount of the premium due from a creditor shall be remitted to the insurer or its producer in accordance with the insurer's requirements. No commissions may be paid to, or retained by, a person or entity except a licensed and appointed insurance producer.

(2) The retention by the creditor of unearned premiums upon cancellation of the insurance without crediting to the debtor's account the amount of unearned insurance charges is prohibited.

(3) Rebates to the creditor of a portion of the premium charged to the debtor are prohibited as are other inducements provided to the creditor by an insurer or producer. The listing of the following activities as prohibited rebates or inducements is not intended to be restrictive, and the commissioner may identify an activity as prohibited by rule, regulation or order:

(a) Allowing insurers or producers to purchase certificates of deposit from the creditor or to maintain accounts with the creditor at less than the market interest rates and charges that the creditor applies to other customers for deposit accounts of similar amounts and duration; and

(b) Paying a commission to a person, including a creditor, who is not appropriately licensed as a producer in this state.

(4) Prohibited rebates or inducements do not include:

(a) The providing of insurance tracking and other services incidental to the creditor-placed insurance program;

(b) The paying of commissions and other compensation to a duly licensed and appointed insurance producer, whether or not affiliated with the creditor;

(c) The paying to the creditor policyholder of group experience rated refunds or policy dividends; and

(d) The paying to the creditor of amounts intended to reimburse the creditor for its expenses incurred incidental to the creditor-placed insurance program (such as costs of data processing, mail processing, telephone service, insurance tracking, billing, collections and related activities); provided that these payments are calculated in a manner that does not exceed an amount reasonably estimated to equal the expenses incurred by the creditor.

(5) Nothing contained in this section shall prohibit or restrict an insurer or producer from maintaining a demand, premium deposit or other account or accounts with a creditor for which the insurer or agent provides insurance if the accounts pay the market interest rate and charges that the creditor applies to other customers for deposit accounts of similar amounts and duration.

HISTORY: Laws, 2001, ch. 307, § 12, eff from and after July 1, 2001.

§ 83-54-25. Creditor to make adequate disclosure to debtor of insurance requirement; "adequate disclosure" defined; when creditor may impose charges; "reasonable efforts" to notify debtor; form of notice; evidence of insurance coverage; creditor not required to insure collateral.

(1) A creditor shall not impose charges, including premium costs and related interest and finance charges, on a debtor for creditor-placed insurance coverage unless adequate disclosure of the requirement to maintain insurance has been made to the debtor. Adequate disclosure is accomplished if the following occurs:

(a) The credit agreement sets forth the requirement that the debtor must maintain insurance on the collateral as provided for in Section 83-54-21;

(b) The creditor makes reasonable efforts to notify the debtor of the requirement to maintain insurance and allows a reasonable time for compliance with this requirement;

(c) A final notice as required by this chapter is sent to the debtor; and

(d) If creditor-placed insurance coverage is issued, a copy of the policy or certificate, with disclosure of premium charged, is sent to the debtor as provided for in Section 83-54-13.

(2) After adequate disclosure of the request to maintain insurance has been made to the debtor as required by this section, a creditor may proceed to impose charges for creditor-placed insurance if the debtor fails to provide evidence of insurance. A creditor may impose charges no earlier than ten (10) calendar days after sending the final notice. However, the charges can be retroactive to the date of exposure to loss.

(3) Reasonable efforts to notify the debtor are accomplished if:

(a) The creditor mails a notice by first-class mail to the debtor's last known address as contained in the creditor's records, stating that the creditor intends to charge the debtor for creditor-placed insurance coverage on the collateral if the debtor fails to provide evidence of the property insurance to the creditor;

(b) The creditor allows the debtor at least twenty (20) calendar days to respond to the notice and provide evidence of acceptable insurance coverage before sending a final notice; and

(c) The creditor sends a final notice in compliance with this section by first-class mail to the debtor's last known address as contained in the creditor's records at least ten (10) calendar days before the cost of insurance is charged to the debtor by the creditor. Proof of the mailing of the final notice shall be retained for at least three (3) years following the expiration or termination of the coverage or as otherwise required by law. A register of letters shall be deemed sufficient proof to satisfy this requirement.

(4) The initial notice shall be in a form determined by the creditor to remind the debtor of the requirement to maintain insurance on the collateral.

The final notice shall be as complete as the following notice, printed in not less than twelve (12) point type, and modified where necessary to fit the nature of the credit transaction:

"FINAL NOTICE

Your credit agreement with us requires you to have property insurance on the collateral until you pay off your loan. You have not given us proof you have insurance on the property. You can ask your insurance company or agent to give us proof of insurance or you can send us proof you have property insurance within ten (10) calendar days after the date this letter was postmarked. If you do not, we will charge you for the insurance we buy.

You must pay for the property insurance we buy. It may cost more than insurance you can buy on your own. The premium of the insurance we buy may be added to your loan balance and we may charge you interest on it. You will be charged interest on the premium at the rate of ________ per annum.

The insurance we buy will pay claims to us (the creditor) for physical damage to your property. It will not pay any claims made against you and it may not pay you for any claims you make. The insurance we buy will not give you any liability insurance coverage and will not meet any other requirements of state law.

We may receive compensation for placing this insurance, which is included in the cost of coverage charged to you.

The property coverage we buy will start on the date shown in the policy or certificate, which may go back to the date of the loan or the date your prior coverage stopped. We will cancel the insurance we bought for you and give you a refund or credit of unearned charges if you give us proof you have bought property insurance somewhere else or if you have paid off the loan."

(5) All creditor-placed insurance shall be set forth in an individual policy or certificate of insurance. Not earlier than the sending of the final notice nor fifteen (15) days after a charge is made to the debtor for creditor-placed insurance coverage, the creditor shall cause a copy of the individual policy, certificate or other evidence of insurance coverage evidencing the creditor-placed insurance coverage to be sent, first-class mail, to the debtor's last known address.

(6) A creditor's compliance with or failure to comply with this chapter shall not be construed to require the creditor to purchase insurance coverage on the collateral, and the creditor shall not be liable to the debtor or a third party as a result of its failure to purchase the insurance.

HISTORY: Laws, 2001, ch. 307, § 13, eff from and after July 1, 2001.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a publishing error in (1)(a) and (d). In (1)(a), the words "Section 11 of this chapter" were changed to "Section 83-54-21." In (1)(d), the words "Section 7 of this chapter" were changed to "Section 83-54-13." The Joint Committee ratified the correction at its July 8, 2004, meeting.

§ 83-54-27. Commissioner of Insurance authorized to conduct investigations of insurers and producers, to deny, suspend, or revoke certificates of authority or producer's licenses, and to impose civil penalties; judicial review of commissioner's orders.

(1) The commissioner may conduct investigations and/or examinations of insurers and producers to ensure compliance with the provisions of this chapter or any rule, regulation or order hereunder, as well as under any other applicable statutes or regulations.

(2) The commissioner may by order, deny, suspend or revoke an insurer's certificate of authority or a producer's license if the commissioner finds that such insurer or producer has violated any provision of this chapter.

(3) If the commissioner has reason to believe that any person or entity is engaging in any activity that would be a violation of this chapter or any rule promulgated under this chapter, the commissioner may issue an order directing that person or entity to cease and desist from committing the violations, impose a civil penalty for the violations, provide an equitable remedy for past violations, or any combination of these. Such order may be issued without prior notice if the commissioner makes a finding that such order is necessary for the protection of policyholders and that the public health, safety and welfare require the order to be issued without prior notice to affected parties. At any hearing or other proceeding conducted as a result of an order to cease and desist, pursuant to this chapter, the person or entity subject to the order shall be required to show cause why such order should be annulled, modified or confirmed.

(4) Whenever it appears to the commissioner that any person or entity has engaged or is about to engage in an act of practice constituting a violation of any provision of this chapter or any rule, regulation or order hereunder, the commissioner may, in the commissioner's discretion, bring an action in chancery court of any county in this state to enjoin the acts or practices and to enforce compliance with this chapter or any rule, regulation or order hereunder. Upon a proper showing, a permanent or temporary injunction, restraining order, writ of mandamus, disgorgement or other proper equitable relief shall be granted.

(5) Additionally, upon a finding that any person or entity has violated a provision of this chapter, the commissioner may impose a civil penalty of not more than One Thousand Dollars ($1,000.00) for each violation, and may revoke, suspend or decline to renew any license of such person or entity to sell or issue insurance.

(6) Any person aggrieved by a final order of the commissioner under this chapter may obtain judicial review of the order in the Circuit Court of Hinds County by filing, within thirty (30) days of the issuance and service of such order, a written petition or complaint praying that said order be modified or set aside. A copy of such petition shall be served upon the commissioner, and the commissioner shall file a complete record of the proceedings with said court,

which shall then have jurisdiction of the proceedings and questions determined therein.

HISTORY: Laws, 2001, ch. 307, § 14, eff from and after July 1, 2001.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a publishing error in (1) and (2). The words "the act" were changed to "this chapter." The Joint Committee ratified the correction at its July 8, 2004, meeting

§ 83-54-29. Rules and regulations.

The commissioner is authorized after notice and hearing to promulgate rules and regulations to effectuate the purposes of this chapter. The commissioner may require such information as is reasonably necessary for the enforcement of this chapter. All rules and regulations adopted and promulgated pursuant to this chapter shall be subject to the Mississippi Administrative Procedures Law, Section 25-43-1.101 et seq.

HISTORY: Laws, 2001, ch. 307, § 15, eff from and after July 1, 2001.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation substituted "Section 25-43-1.101 et seq." for "Section 25-43-1 et seq." at the end of the last sentence. The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-54-31. Severability.

If any provision of this chapter or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the chapter which can be given effect without the invalid provision or application, and to that end the provisions of this chapter are declared to be severable.

HISTORY: Laws, 2001, ch. 307, § 16, eff from and after July 1, 2001.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a publishing error. The word "act" was changed to "chapter."The Joint Committee ratified the correction at its July 8, 2004, meeting.

CHAPTER 55.

RISK RETENTION ACT

Sec.

83-55-1. Purpose.
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83-55-5. Chartering of risk retention groups; submission of plan of operation; revisions of plan; information required.
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§ 83-55-1. Purpose.

The purpose of this chapter is to regulate the formation and/or operation of risk retention groups and purchasing groups in this state formed pursuant to the provisions of the federal Liability Risk Retention Act of 1986 ("RRA 1986"), to the extent permitted by such law.

HISTORY: Laws, 1988, ch. 419, § 1, eff from and after July 1, 1988.

Federal Aspects — The Liability Risk Retention Act of 1986 is codified in 15 USCS § 3901 et seq.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 29, 36, 55, 82, 83, 667-714, 1004, 1005.

Practice References.
Business Law Monographs, Volume IN2—Casualty and Liability Insurance (Matthew Bender).

§ 83-55-3. Definitions.

For the purposes of this chapter, the following words shall have the meanings ascribed herein, unless the context otherwise requires:

(a) "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

(b) "Completed operations liability" means liability arising out of the installation, maintenance or repair of any product at a site which is not owned or controlled by:

(i) Any person who performs that work; or

(ii) Any person who hires an independent contractor to perform that work, but shall include liability for activities which are completed or abandoned before the date of the occurrence giving rise to the liability.

(c) "Domicile," for purposes of determining the state in which a purchasing group is domiciled, means:

(i) For a corporation, the state in which the purchasing group is incorporated; and

(ii) For an unincorporated entity, the state of its principal place of business.

(d) "Hazardous financial condition" means that, based on its present or reasonably anticipated financial condition, a risk retention group, although not yet financially impaired or insolvent, is unlikely to be able:

(i) To meet obligations to policyholders with respect to known claims and reasonably anticipated claims; or

(ii) To pay other obligations in the normal course of business.

(e) "Insurance" means primary insurance, excess insurance, reinsurance, surplus lines insurance, and any other arrangement for shifting and distributing risk which is determined to be insurance under the laws of this state.

(f) "Liability"

(i) Means legal liability for damages (including costs of defense, legal costs and fees, and other claims expenses) because of injuries to other persons, damage to their property, or other damage or loss to such other persons resulting from or arising out of:

1. Any business (whether profit or nonprofit), trade, product, services (including professional services), premises or operations; or

2. Any activity of any state or local government, or any agency or political subdivision thereof; and

(ii) Does not include personal risk liability and an employer's liability with respect to its employees other than legal liability under the Federal Employers' Liability Act (45 U.S.C. 51 et seq).

(g) "Personal risk liability" means liability for damages because of injury to any person, damage to property, or other loss or damage resulting from any personal, familial or household responsibilities or activities, rather than from responsibilities or activities referred to in subparagraph (vi) of paragraph 2(h).

(h) "Plan of operation or a feasibility study" means an analysis which presents the expected activities and results of a risk retention group including, at a minimum:

(i) Information sufficient to verify that its members are engaged in businesses or activities similar or related with respect to the liability to which such members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations;

(ii) For each state in which it intends to operate, the coverages, deductibles, coverage limits, rates and rating classification systems for each line of insurance the group intends to offer;

(iii) Historical and expected loss experience of the proposed members and national experience of similar exposures to the extent that this experience is reasonably available;

(iv) Pro forma financial statements and projections;

(v) Appropriate opinions by a qualified, independent casualty actuary, including a determination of minimum premium or participation levels required to commence operations and to prevent a hazardous financial condition;

(vi) Identification of management, underwriting and claims procedures, marketing methods, managerial oversight methods, investment policies and reinsurance agreements;

(vii) Identification of each state in which the risk retention group has obtained, or sought to obtain, a charter and license, and a description of its status in each such state; and

(viii) Such other matters as may be prescribed by the Commissioner of the state in which the risk retention group is chartered for liability insurance companies authorized by the insurance laws of that state.

(i) "Product liability" means liability for damages because of any personal injury, death, emotional harm, consequential economic damage or property damage (including damages resulting from the loss of use of property) arising out of the manufacture, design, importation, distribution, packaging, labeling, lease or sale of a product, but does not include the liability of any person for those damages if the product involved was in the possession of such person when the incident giving rise to the claim occurred.

(j) "Purchasing group" means any group which:

(i) Has as one (1) of its purposes the purchase of liability insurance on a group basis;

(ii) Purchases such insurance only for its group members and only to cover their similar or related liability exposure, as described in subparagraph (iii);

(iii) Is composed of members whose businesses or activities are similar or related with respect to the liability to which members are exposed by virtue of any related, similar or common business, trade, product, services, premises or operations; and

(iv) Is domiciled in any state.

(k) "Risk retention group" means any corporation or other limited liability association:

(i) Whose primary activity consists of assuming and spreading all, or any portion, of the liability exposure of its group members;

(ii) Which is organized for the primary purpose of conducting the activity described under subparagraph (i);

(iii) Which:

1. Is chartered and licensed as a liability insurance company and authorized to engage in the business of insurance under the laws of any state; or

2. Before January 1, 1985, was chartered or licensed and authorized to engage in the business of insurance under the laws of Bermuda or the Cayman Islands and, before such date, had certified to the Insurance Commissioner of at least one (1) state that it satisfied the capitalization requirements of such state, except that any such group shall be considered to be a risk retention group only if it has been engaged in business continuously since such date and only for the purpose of continuing to provide insurance to cover product liability or completed operations liability (as such terms were defined in the Product Liability Risk Retention Act of 1981 before the date of the enactment of the Liability Risk Retention Act of 1986);

(iv) Which does not exclude any person from membership in the group solely to provide for members of such group a competitive advantage over such person;

(v) Which:

1. Has as its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group; or

2. Has as its sole owner an organization which has as:

a. Its members only persons who comprise the membership of the risk retention group; and

b. Its owners only persons who comprise the membership of the risk retention group and who are provided insurance by such group;

(vi) Whose members are engaged in businesses or activities similar or related with respect to the liability of which such members are exposed by virtue of any related, similar or common business trade, product, services, premises or operations;

(vii) Whose activities do not include the provision of insurance other than:

1. Liability insurance for assuming and spreading all or any portion of the liability of its group members; and

2. Reinsurance with respect to the liability of any other risk retention group (or any members of such other group) which is engaged in businesses or activities so that such group or member meets the requirement described in subparagraph (vi) from membership in the risk retention group which provides such reinsurance; and

(viii) The name of which includes the phrase "Risk Retention Group."

(*l*) "State" means any state of the United States or the District of Columbia.

HISTORY: Laws, 1988, ch. 419, § 2, eff from and after July 1, 1988.

Cross References — Requirement that out-of-state chartered and licensed risk retention groups submit information verifying that they qualify under this section as a "risk retention group," see § 83-55-7.

Requirement that purchasing groups provide information verifying that they qualify as a "purchasing group" under this section, see § 83-55-15.

Federal Aspects — Product Liability Risk Retention Act of 1981 is codified as 15 USCS § 3901 et seq. Liability Risk Retention Act of 1986 is codified in 15 USCS § 3901 et seq., effective October 27, 1986. Federal Employers' Liability Act is codifies in 45 USCS § 51 et seq.

RESEARCH REFERENCES

ALR.

Excessiveness or adequacy of damages awarded for injuries to nerves or nervous system. 51 A.L.R.5th 467.

Excessiveness or adequacy of damages awarded for injuries causing mental or psychological damages. 52 A.L.R.5th 1.

Requirement that multicoverage umbrella insurance policy offer uninsured-or underinsured-motorist coverage equal to liability limits under umbrella provisions. 52 A.L.R.5th 451.

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 29, 36, 55, 82, 83, 667-714, 1004, 1005.

§ 83-55-5. Chartering of risk retention groups; submission of plan of operation; revisions of plan; information required.

(1) A risk retention group shall, pursuant to the provisions of the laws of this state be chartered and licensed to write only liability insurance pursuant to this chapter and, except as provided elsewhere in this chapter, must comply with all of the laws, rules, regulations and requirements applicable to such insurers chartered and licensed in this state and with Section 83-55-7 to the extent such requirements are not a limitation on laws, rules, regulations or requirements of this state.

(2) Before it may offer insurance in any state, each risk retention group shall also submit for approval to the Insurance Commissioner of this state a plan of operation or feasibility study. The risk retention group shall submit an appropriate revision in the event of any subsequent material change in any item of the plan of operation or feasibility study, within ten (10) days of any such change. The group shall not offer any additional kinds of liability insurance, in this state or in any other state, until a revision of such plan or study is approved by the Commissioner.

(3) At the time of filing its application for charter, the risk retention group shall provide to the Commissioner in summary form the following information: The identity of the initial members of the group, the identity of those individuals who organized the group or who will provide administrative

services or otherwise influence or control the activities of the group, the amount and nature of initial capitalization, the coverages to be afforded and the states in which the group intends to operate. Upon receipt of this information, the Commissioner shall forward such information to the National Association of Insurance Commissioners (NAIC). Providing notification to the National Association of Insurance Commissioners is in addition to and shall not be sufficient to satisfy the requirements of Section 83-55-7 or any other sections of this chapter.

HISTORY: Laws, 1988, ch. 419, § 3, eff from and after July 1, 1988.

Cross References — Requirement that risk retention groups submit a copy of any revision to the plan of operation required by this section, see § 83-55-7.

§ 83-55-7. Out-of-state chartered risk retention groups; requirements for doing business in state.

Risk retention groups chartered and licensed in states other than this state and seeking to do business as a risk retention group in this state shall comply with the laws of this state as follows:

(a) Notice of operations and designation of Commissioner as agent.

(i) Before offering insurance in this state, a risk retention group shall submit to the Commissioner:

1. A statement identifying the state or states in which the risk retention group is chartered and licensed as a liability insurance company, charter date, its principal place of business, and such other information, including information on its membership, as the Commissioner of this state may require to verify that the risk retention group is qualified under Section 83-55-3(k);

2. A copy of its plan of operations or feasibility study and revisions of such plan or study submitted to the state in which the risk retention group is chartered and licensed; provided, however, that the provision relating to the submission of a plan of operation or feasibility study shall not apply with respect to any line or classification of liability insurance which:

a. Was defined in the Product Liability Risk Retention Act of 1981 before October 27, 1986; and

b. Was offered before such date by any risk retention group which had been chartered and operating for not less than three (3) years before such date; and

(ii) The risk retention group shall submit a copy of any revision to its plan of operation or feasibility study required by Section 83-55-5(2) at the same time that such revision is submitted to the Commissioner of its chartering state.

(iii) A statement of registration, for which a filing fee shall be determined by the Commissioner, which designates the Commissioner as its agent for the purpose of receiving service of legal documents or process.

(b) Financial condition. Any risk retention group doing business in this state shall submit to the Commissioner:

(i) A copy of the group's financial statement submitted to the state in which the risk retention group is chartered and licensed which shall be certified by an independent public accountant and contain a statement of opinion on loss and loss adjustment expense reserves made by a member of the American Academy of Actuaries or a qualified loss reserve specialist (under criteria established by the National Association of Insurance Commissioners);

(ii) A copy of each examination of the risk retention group as certified by the Commissioner or public official conducting the examination;

(iii) Upon request by the Commissioner, a copy of any information or document pertaining to any outside audit performed with respect to the risk retention group; and

(iv) Such information as may be required to verify its continuing qualification as a risk retention group under Section 83-55-3(k).

(c) Taxation.

(i) Each risk retention group shall be liable for the payment of premium taxes and taxes on premiums of direct business for risks resident or located within this state, and shall report to the Commissioner the net premiums written for risks resident or located within this state. Such risk retention group shall be subject to taxation, and any applicable fines and penalties related thereto, on the same basis as a foreign admitted insurer.

(ii) To the extent licensed agents or brokers are utilized pursuant to Section 83-55-23, they shall report to the Commissioner the premiums for direct business for risks resident or located within this state which such licensees have placed with or on behalf of a risk retention group not chartered in this state.

(iii) To the extent that insurance agents or brokers are utilized pursuant to Section 83-55-23, such agent or broker shall keep a complete and separate record of all policies procured from each such risk retention group, which record shall be open to examination by the Commissioner, as provided in Section 83-5-65, Mississippi Code of 1972. These records shall, for each policy and each kind of insurance provided thereunder, include the following:

1. The limit of liability;
2. The time period covered;
3. The effective date;
4. The name of the risk retention group which issued the policy;
5. The gross premium charged; and
6. The amount of return premiums, if any.

(d) Deceptive, false or fraudulent practices. Any risk retention group shall comply with Sections 83-5-29 through 83-5-51, Mississippi Code of 1972, regarding deceptive, false or fraudulent acts or practices. However, if the Commissioner seeks an injunction regarding such conduct, the injunction must be obtained from a court of competent jurisdiction.

(e) Examination regarding financial condition. Any risk retention group must submit to an examination by the Commissioner to determine its financial condition if the Commissioner of the jurisdiction in which the group is chartered and licensed has not initiated an examination or does not initiate an examination within sixty (60) days after a request by the Commissioner of this state. Any such examination shall be coordinated to avoid unjustified repetition and conducted in an expeditious manner and in accordance with the NAIC's Examiner Handbook.

(f) Notice to Purchasers. Every application form for insurance from a risk retention group, and every policy (on its front and declaration pages) issued by a risk retention group, shall contain in ten-point type the following notice:

NOTICE

This policy is issued by your risk retention group. Your risk retention group may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guaranty funds are not available for your risk retention group.

(g) Prohibited acts regarding solicitation or sale. The following acts by a risk retention group are hereby prohibited:

(i) The solicitation or sale of insurance by a risk retention group to any person who is not eligible for membership in such group; and

(ii) The solicitation or sale of insurance by, or operation of, a risk retention group that is in hazardous financial condition or financially impaired.

(h) Prohibition on ownership by an insurance company. No risk retention group shall be allowed to do business in this state if an insurance company is directly or indirectly a member or owner of such risk retention group, other than in the case of a risk retention group all of whose members are insurance companies.

(i) Prohibited coverage. The terms of any insurance policy issued by any risk retention group shall not provide, or be construed to provide, coverage prohibited generally by statute of this state or declared unlawful by the highest court of this state whose law applies to such policy.

(j) Delinquency proceedings. A risk retention group not chartered in this state and doing business in this state shall comply with a lawful order issued in a voluntary dissolution proceeding or in a delinquency proceeding commenced by a State Insurance Commissioner if there has been a finding of financial impairment after an examination.

(k) Penalties. A risk retention group that violates any provision of this chapter will be subject to fines and penalties including revocation of its right to do business in this state, applicable to licensed insurers generally.

(*l*) Operation prior to July 1, 1988. In addition to complying with the requirements of this section, any risk retention group operating in this state prior to July 1, 1988, shall, within thirty (30) days after July 1, 1988, comply with the provision of paragraph (a)(i) of this section.

HISTORY: Laws, 1988, ch. 419, § 4, eff from and after July 1, 1988.

Cross References — Requirement that risk retention groups comply with the provisions of this section, and exceptions thereto, see § 83-55-5.

Provision that notice to the National Association of Insurance Commissioners (NAIC) is not sufficient to satisfy the requirements of this section, see § 83-55-5.

Requirement that each prospective insured be informed of the provisions of the notice required by this section, see § 83-55-23.

Federal Aspects — The Product Liability Risk Retention Act of 1981 is codified as 15 USCS §§ 3901 et seq.

§ 83-55-9. Risk retention groups not to participate in insolvency guaranty funds; no benefits to be received from funds.

(1) No risk retention group shall be required or permitted to join or contribute financially to any insurance insolvency guaranty fund or similar mechanism, in this state, nor shall any risk retention group, or its insureds or claimants against its insureds, receive any benefit from any such fund for claims arising under the insurance policies issued by such risk retention group.

(2) When a purchasing group obtains insurance covering its members' risks from an insurer not authorized in this state or a risk retention group, no such risks, wherever resident or located, shall be covered by any insurance guaranty fund or similar mechanism in this state.

(3) When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state shall be covered by any state guaranty fund.

HISTORY: Laws, 1988, ch. 419, § 5, eff from and after July 1, 1988.

§ 83-55-11. Policy not required to be countersigned.

A policy of insurance issued to a risk retention group or any member of that group shall not be required to be countersigned.

HISTORY: Laws, 1988, ch. 419, § 6, eff from and after July 1, 1988.

§ 83-55-13. Purchasing group and insurer subject to all applicable state laws; exceptions.

A purchasing group and its insurer or insurers shall be subject to all applicable laws of this state, except that a purchasing group and its insurer or insurers shall be exempt, in regard to liability insurance for the purchasing group, from any law that would:

(a) Prohibit the establishment of a purchasing group;

(b) Make it unlawful for an insurer to provide or offer to provide insurance on a basis providing, to a purchasing group or its members, advantages based on their loss and expense experience not afforded to other persons with respect to rates, policy forms, coverages or other matters;

(c) Prohibit a purchasing group or its members from purchasing insurance on a group basis described in paragraph (b) of this section;

(d) Prohibit a purchasing group from obtaining insurance on a group basis because the group has not been in existence for a minimum period of time or because any member has not belonged to the group for a minimum period of time;

(e) Require that a purchasing group must have a minimum number of members, common ownership or affiliation or certain legal form;

(f) Require that a certain percentage of a purchasing group must obtain insurance on a group basis;

(g) Otherwise discriminate against a purchasing group or any of its members; or

(h) Require that any insurance policy issued to a purchasing group or any of its members be countersigned by an insurance agent or broker residing in this state.

HISTORY: Laws, 1988, ch. 419, § 7, eff from and after July 1, 1988.

§ 83-55-15. Purchasing group; notice of intent to do business; commissioner as agent for service; additional information required; preexisting groups.

(1) A purchasing group which intends to do business in this state shall, prior to doing business, furnish notice to the Commissioner which shall:

(a) Identify the state in which the group is domiciled;

(b) Identify all other states in which the group intends to do business;

(c) Specify the lines and classifications of liability insurance which the purchasing group intends to purchase;

(d) Identify the insurance company or companies from which the group intends to purchase its insurance and the domicile of such company;

(e) Specify the method by which, and the person or persons, if any, through whom insurance will be offered to its members whose risks are resident or located in this state;

(f) Identify the principal place of business of the group; and

(g) Provide such other information as may be required by the Commissioner to verify that the purchasing group is qualified under Section 83-55-3(j).

(2) A purchasing group shall, within ten (10) days, notify the Commissioner of any changes in any of the items set forth in subsection (1) of this section.

(3) The purchasing group shall register with and designate the Commissioner (or other appropriate authority) as its agent solely for the purpose of receiving service of legal documents or process, for which a filing fee shall be determined by the Commissioner, except that such requirements shall not apply in the case of a purchasing group which only purchases insurance that was authorized under the Federal Products Liability Risk Retention Act of 1981, and

(a) Which in any state of the United States:

(i) Was domiciled before April 1, 1986; and

(ii) Is domiciled on and after October 27, 1986;

(b) Which:

(i) Before October 27, 1986, purchased insurance from an insurance carrier licensed in any state; and

(ii) Since October 27, 1986, purchased its insurance from an insurance carrier licensed in any state; or

(c) Which was a purchasing group under the requirements of the Product Liability Risk Retention Act of 1981 before October 27, 1986.

(4) Each purchasing group that is required to give notice pursuant to subsection (1) of this section shall also furnish such information as may be required by the Commissioner to:

(a) Verify that the entity qualifies as a purchasing group;

(b) Determine where the purchasing group is located; and

(c) Determine appropriate tax treatment.

(5) Any purchasing group which was doing business in this state prior to July 1, 1988, shall, within thirty (30) days after July 1, 1988, furnish notice to the Commissioner pursuant to the provisions of subsection (1) of this section and furnish such information as may be required pursuant to subsections (2) and (3) of this section.

HISTORY: Laws, 1988, ch. 419, § 8, eff from and after July 1, 1988.

Federal Aspects — The Product Liability Risk Retention Act of 1981 is codified as 15 USCS § 3901 et seq.

§ 83-55-16. Payment of annual fee to continue to do business in state; penalties for failure to pay fee; filing of annual reports.

(1) Each risk retention group or risk purchasing group which wishes to do or continue to do business in this state shall annually register on or before March 1 of each year. Should a risk retention group or risk purchasing group fail to timely register, the commissioner shall immediately revoke without notice or hearing any registration held by the entity.

(2) Each risk retention group or risk purchasing group operating in the State of Mississippi shall file with the Mississippi Department of Insurance on or before March 1 of each year a listing of the premiums written on risks in Mississippi.

HISTORY: Laws, 1999, ch. 343, § 1; Laws, 2006, ch. 496, § 1, eff from and after July 1, 2006.

§ 83-55-17. Purchase of insurance from non-state chartered group or non-state admitted insurer; notice requirements; deductible or self-insured retention not permitted; aggregate limits on purchases.

(1) A purchasing group may not purchase insurance from a risk retention

group that is not chartered in a state or from an insurer not admitted in the state in which the purchasing group is located, unless the purchase is effected through a licensed agent or broker acting pursuant to the surplus lines laws and regulations of such state.

(2) A purchasing group which obtains liability insurance from an insurer not admitted in this state or a risk retention group shall inform each of the members of such group which have a risk resident or located in this state that such risk is not protected by an insurance insolvency guaranty fund in this state, and that such risk retention group or such insurer may not be subject to all insurance laws and regulations of this state.

(3) No purchasing group may purchase insurance providing for a deductible or self-insured retention applicable to the group as a whole; however, coverage may provide for a deductible or self-insured retention applicable to individual members.

(4) Purchases of insurance by purchasing groups are subject to the same standards regarding aggregate limits which are applicable to all purchases of group insurance.

HISTORY: Laws, 1988, ch. 419, § 9, eff from and after July 1, 1988.

Cross References — Requirement that each prospective insured be informed of the provisions of the notice required by this section, see § 83-55-23.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 29, 36, 55, 82, 83, 667-714, 1004, 1005.

§ 83-55-19. Premium taxes.

Premium taxes and taxes on premiums paid for coverage of risks resident or located in this state by a purchasing group or any members of the purchasing groups shall be:

(a) Imposed at the same rate and subject to the same interest, fines and penalties as that applicable to premium taxes and taxes on premiums paid for similar coverage from a similar insurance source by other insureds; and

(b) Paid first by such insurance source, and if not by such source by the agent or broker for the purchasing group, and if not by such agent or broker then by the purchasing group, and if not by such purchasing group then by each of its members.

HISTORY: Laws, 1988, ch. 419, § 10, eff from and after July 1, 1988.

§ 83-55-21. Powers of commissioner; applicable procedures; injunctive relief.

The Commissioner is authorized to make use of any of the powers established under the Insurance Laws of this state to enforce the laws of this state not specifically preempted by the Risk Retention Act of 1986, including the Commissioner's administrative authority to investigate, issue subpoena, conduct depositions and hearings, issue orders, impose penalties and seek injunctive relief. With regard to any investigation, administrative proceedings or litigation, the Commissioner can rely on the procedural laws of this state. The injunctive authority of the Commissioner, in regard to risk retention groups, is restricted by the requirement that any injunction be issued by a court of competent jurisdiction.

HISTORY: Laws, 1988, ch. 419, § 11, eff from and after July 1, 1988.

Federal Aspects — Risk Retention Act of 1986 is codified as 15 USCS § 3901 et seq.

§ 83-55-23. License required to solicit, negotiate or procure liability insurance; notice to insured.

(1) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance in this state from a risk retention group unless such person, firm, association or corporation is licensed as an insurance agent or broker in accordance with the laws of this state.

(2) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance in this state for a purchasing group from an authorized insurer or a risk retention group chartered in a state unless such person, firm, association or corporation is licensed as an insurance agent or broker in accordance with the laws of this state.

(3) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance coverage in this state for any member of a purchasing group under a purchasing group's policy unless such person, firm, association or corporation is licensed as an insurance agent or broker in accordance with the laws of this state.

(4) No person, firm, association or corporation shall act or aid in any manner in soliciting, negotiating or procuring liability insurance from an insurer not authorized to do business in this state on behalf of a purchasing group located in this state unless such person, firm, association or corporation is licensed as a surplus lines agent or excess line broker in accordance with the laws of this state.

(5) For purposes of acting as an agent or broker for a risk retention group or purchasing group pursuant to subsections (1) and (2) of this section, the requirement of residence in this state shall not apply.

(6) Every person, firm, association or corporation licensed pursuant to the laws of this state, on business placed with risk retention groups or written through a purchasing group, shall inform each prospective insured of the provisions of the notice required by paragraph (f) of Section 83-55-7 in the case of a risk retention group and subsection (2) of Section 83-55-17 in the case of a purchasing group.

HISTORY: Laws, 1988, ch. 419, § 12, eff from and after July 1, 1988.

Cross References — Reporting and record keeping requirements applicable to agents and brokers utilized pursuant to this section, see § 83-55-7.

RESEARCH REFERENCES

Am. Jur.
43 Am. Jur. 2d, Insurance §§ 29, 36, 55, 82, 83, 667-714, 1004, 1005.

§ 83-55-25. U.S. District Court injunctions enforceable in state courts.

An order issued by any District Court of the United States enjoining a risk retention group from soliciting or selling insurance, or operating in any state (or in all states or in any territory or possession of the United States) upon a finding that such a group is in hazardous financial or financially impaired condition shall be enforceable in the courts of this state.

HISTORY: Laws, 1988, ch. 419, § 13, eff from and after July 1, 1988.

§ 83-55-27. Rules and regulations.

The Commissioner may establish and from time to time amend such rules and regulations relating to risk retention groups as may be necessary or desirable to carry out the provisions of this chapter.

HISTORY: Laws, 1988, ch. 419, § 14, eff from and after July 1, 1988.

§ 83-55-29. Saving clause.

If any clause, sentence, paragraph, section or part of this chapter or the application thereof to any person or circumstances, shall, for any reason, be adjudged by any court of competent jurisdiction to be invalid, such judgment shall not affect, impair or invalidate the remainder of this chapter, and the application thereof to other persons or circumstances, but shall be confined in its operation to the clause, sentence, paragraph, section or part thereof directly involved in the controversy in which such judgment shall have been rendered and to the person or circumstances involved.

HISTORY: Laws, 1988, ch. 419, § 15, eff from and after July 1, 1988.

CHAPTER 57.

HOME WARRANTIES [REPEALED]

Sec.
83-57-1 through 83-57-79. Repealed.

§§ 83-57-1 through 83-57-79. Repealed.

Repealed by Laws, 2003, ch. 386, § 2, eff from and after March 14, 2003.

§ 83-57-1. [Laws, 1988, ch. 525, § 1, eff from and after July 1, 1988.]

§ 83-57-3. [Laws, 1988, ch. 525, § 2, eff from and after July 1, 1988.]

§ 83-57-5. [Laws, 1988, ch. 525, § 3, eff from and after July 1, 1988.]

§ 83-57-7. [Laws, 1988, ch. 525, § 4, eff from and after July 1, 1988.]

§ 83-57-9. [Laws, 1988, ch. 525, § 5, eff from and after July 1, 1988.]

§ 83-57-11. [Laws, 1988, ch. 525, § 6, eff from and after July 1, 1988.]

§ 83-57-13. [Laws, 1988, ch. 525, § 7, Laws 1999, ch. 346, § 1, eff from and after July 1, 1988.]

§ 83-57-15. [Laws, 1988, ch. 525, § 8, eff from and after July 1, 1988.]

§ 83-57-17. [Laws, 1988, ch. 525, § 9, eff from and after July 1, 1988.]

§ 83-57-19. [Laws, 1988, ch. 525, § 10, eff from and after July 1, 1988.]

§ 83-57-21. [Laws, 1988, ch. 525, § 11, eff from and after July 1, 1988.]

§ 83-57-23. [Laws, 1988, ch. 525, § 12, eff from and after July 1, 1988.]

§ 83-57-25. [Laws, 1988, ch. 525, § 13, eff from and after July 1, 1988.]

§ 83-57-27. [Laws, 1988, ch. 525, § 14, eff from and after July 1, 1988.]

§ 83-57-29. [Laws, 1988, ch. 525, § 15, eff from and after July 1, 1988.]

§ 83-57-31. [Laws, 1988, ch. 525, § 16; Laws, 1999, ch. 315, § 1, eff from and after July 1, 1999.]

§ 83-57-33. [Laws, 1988, ch. 525, § 17, eff from and after July 1, 1988.]

§ 83-57-35. [Laws, 1988, ch. 525, § 18, eff from and after July 1, 1988.]

§ 83-57-37. [Laws, 1988, ch. 525, § 19, eff from and after July 1, 1988.]

§ 83-57-39. [Laws, 1988, ch. 525, § 20, eff from and after July 1, 1988.]

§ 83-57-41. [Laws, 1988, ch. 525, § 21, eff from and after July 1, 1988.]

§ 83-57-43. [Laws, 1988, ch. 525, § 22, eff from and after July 1, 1988.]

§ 83-57-45. [Laws, 1988, ch. 525, § 23, eff from and after July 1, 1988.]

§ 83-57-47. [Laws, 1988, ch. 525, § 24, eff from and after July 1, 1988.]

§ 83-57-49. [Laws, 1988, ch. 525, § 25, eff from and after July 1, 1988.]

§ 83-57-51. [Laws, 1988, ch. 525, § 26, eff from and after July 1, 1988.]

§ 83-57-53. [Laws, 1988, ch. 525, § 27, eff from and after July 1, 1988.]

§ 83-57-55. [Laws, 1988, ch. 525, § 28, eff from and after July 1, 1988.]

§ 83-57-57. [Laws, 1988, ch. 525, § 29, eff from and after July 1, 1988.]

§ 83-57-59. [Laws, 1988, ch. 525, § 30, eff from and after July 1, 1988.]

§ 83-57-61. [Laws, 1988, ch. 525, § 31, eff from and after July 1, 1988.]

§ 83-57-63. [Laws, 1988, ch. 525, § 32, eff from and after July 1, 1988.]

§ 83-57-65. [Laws, 1988, ch. 525, § 33, eff from and after July 1, 1988.]

§ 83-57-67. [Laws, 1988, ch. 525, § 34, eff from and after July 1, 1988.]

§ 83-57-69. [Laws, 1988, ch. 525, § 35, eff from and after July 1, 1988.]
§ 83-57-71. [Laws, 1988, ch. 525, § 36, eff from and after July 1, 1988.]
§ 83-57-73. [Laws, 1988, ch. 525, § 37, eff from and after July 1, 1988.]
§ 83-57-75. [Laws, 1988, ch. 525, § 38, eff from and after July 1, 1988.]
§ 83-57-77. [Laws, 1988, ch. 525, § 39, eff from and after July 1, 1988.]
§ 83-57-79. [Laws, 1988, ch. 525, § 40, eff from and after July 1, 1988.]

Editor's Notes — Laws of 2003, ch. 386, § 3, provides:

"SECTION 3. This act shall take effect and be in force from and after its passage, and shall be applicable to all proceedings pending before the Department of Insurance or the courts of this state on the effective date of this act." Laws of 2003, ch. 386, became effective upon the signature of the Governor on March 14, 2003.

Former §§ 83-57-1 through 83-57-79 provided for the regulation of home warranties by the Commissioner of Insurance. For current similar provisions pertaining to regulation of service contracts, home warranties, and home service contracts under the Mississippi Consumer Protection Act, see § 75-24-91. For present provisions relating to new home warranties, see §§ 83-58-1 et seq.

Former § 83-57-1 was entitled: "Home warranties to be regulated by Insurance Department; vendors to be licensed."

Former § 83-57-3 was entitled: "Definitions."

Former § 83-57-5 was entitled: "Administration of chapter; rules and regulations."

Former § 83-57-7 was entitled: "License required to provide home warranties; exception; requirements for license."

Former § 83-57-9 was entitled: "Deposit of securities or bonds to assure performance."

Former § 83-57-11 was entitled: "Application for license; issuance, refusal, and renewal of license."

Former § 83-57-13 was entitled: "Funded, unearned premium reserve; net assets; liability insurance in lieu of reserve."

Former § 83-57-15 was entitled: "Grounds for revocation, suspension or refusal to renew license; notice and hearing requirements."

Former § 83-57-17 was entitled: "Notice of suspension or revocation of license."

Former § 83-57-19 was entitled: "Suspension of license; reinstatement of license."

Former § 83-57-21 was entitled: "Fine in lieu of suspension, revocation or refusal to renew; nonwillful violations; willful violations; restitution."

Former § 83-57-23 was entitled: "Warranty forms; filing requirements; disapproval of forms."

Former § 83-57-25 was entitled: "Filing of rate and premium schedules; approval or disapproval."

Former § 83-57-27 was entitled: "Filing of annual statement; information required; premium taxes."

Former § 83-57-29 was entitled: "Records."

Former § 83-57-31 was entitled: "Financial examinations of home warranty associations."

Former § 83-57-33 was entitled: "Service of process on home warranty associations."

Former § 83-57-35 was entitled: "Registration of sales representatives."

Former § 83-57-37 was entitled: "Funds received by sales representatives are trust funds; accounting for funds received; penalty for appropriating funds to own use."

Former § 83-57-39 was entitled: "Grounds for suspension, revocation or refusal to renew registration of sales representative."

Former § 83-57-41 was entitled: "Violations of chapter by representative; automatic revocation of registration; suspension of registration; reinstatement; revocation of registration; reregistration; former registrant not to engage in activities requiring registration."

Former § 83-57-43 was entitled: "Fine in lieu of suspension or revocation of, or refusal to renew, registration."

Former § 83-57-45 was entitled: "Taxes, fees, fines and penalties to be deposited to general fund."

Former § 83-57-47 was entitled: "Authorization under chapter limited to business of home warranty."

Former § 83-57-49 was entitled: "Fronting" company.

Former § 83-57-51 was entitled: "Chapter inapplicable to certain licensed insurers."

Former § 83-57-53 was entitled: "Penalty for making false application for registration or violating this chapter."

Former § 83-57-55 was entitled: "Civil action for violation of this chapter authorized; notice requirements; class actions not authorized."

Former § 83-57-57 was entitled: "Dissolution or liquidation of corporation subject to this chapter."

Former § 83-57-59 was entitled: "Unfair trade practice prohibited; unfair methods of competition and unfair or deceptive acts or practices defined."

Former § 83-57-61 was entitled: "Examinations and investigations of unfair trade practices."

Former § 83-57-63 was entitled: "Hearings; orders; penalties."

Former § 83-57-65 was entitled: "Appeal of order."

Former § 83-57-67 was entitled: "Penalties for violating order."

Former § 83-57-69 was entitled: "Injunction relief."

Former § 83-57-71 was entitled: "Provisions of chapter cumulative."

Former § 83-57-73 was entitled: "Lending of money or extension of credit conditioned on purchase of home warranty prohibited; notice to borrower or purchaser."

Former § 83-57-75 was entitled: "Notice or right to cancel home warranty purchased in connection with loan."

Former § 83-57-77 was entitled: "Confidentiality of records."

Former § 83-57-79 was entitled: "Ineligibility of certain persons to be licensed to sell home warranties."

CHAPTER 58.

NEW HOME WARRANTY ACT

Sec.	
83-58-1.	Short title.
83-58-3.	Definitions.
83-58-5.	Builder's warranties to owner.
83-58-7.	Written notice of defect to builder.
83-58-9.	Commencement of warranty action.
83-58-11.	Insurance for warranty allegations.
83-58-13.	Transfer of warranties.
83-58-15.	Damages; arbitration of claims.
83-58-17.	Statutory remedy for damages arising from violations of home warranty law; common law remedies.

§ 83-58-1. Short title.

This chapter shall be known and may be cited as the "New Home Warranty Act."

HISTORY: Laws, 1997, ch. 465, § 1, eff from and after July 1, 1997.

Editor's Notes — Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

RESEARCH REFERENCES

ALR.
Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.
Validity, construction, and application of new home warranty acts. 101 A.L.R.5th 447.

Am. Jur.
77 Am. Jur. 2d, Vendor and Purchaser § 283.

§ 83-58-3. Definitions.

For purposes of this chapter the following words and phrases shall have the meanings ascribed herein unless the context clearly indicates otherwise:

(a) "Builder" means any person, corporation, partnership, or other entity which constructs a home or engages another to construct a home, including a home occupied initially by its builder as his residence, for the purpose of sale.

(b) "Building standards" means the standards contained in the building code, mechanical-plumbing code, and electrical code in effect in the county, municipality or other local political subdivision where a home is to be located, at the time construction of that home is commenced, or, if the county, city or other local political subdivision has not adopted such codes, the Standard Building Code, together with any additional performance standards, if any, which the builder may undertake to be in compliance.

(c) "Home" means any new structure designed and used only for residential use.

(d) "Initial purchaser" means any person for whom a home is built or the first person to whom a home is sold upon completion of construction.

(e) "Major structural defect" means actual physical damage to any of the following load-bearing portions of a home caused by failure of the load-bearing portions and its load-bearing functions, as follows to wit:

(i) Foundation systems and footings;
(ii) Beams;
(iii) Girders;
(iv) Lintels;
(v) Columns;
(vi) Load-bearing walls and partitions;
(vii) Floor systems;
(viii) Roof-framing systems.

(f) "Owner" means the initial purchaser of a home and any of his successors in title to a home during the time the warranties provided under this chapter are in effect.

(g) "Warranty commencement date" means the date that legal title to a home is conveyed to its initial purchaser or the date the home is first occupied, whichever occurs first.

HISTORY: Laws, 1997, ch. 465, § 2; Laws, 2012, ch. 405, § 1, eff from and after July 1, 2012.

Editor's Notes — Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

JUDICIAL DECISIONS

ANALYSIS

1. Building standards.
2. Limitations period.
3. Builder.

1. Building standards.

Builder was liable to two owners for defects in a new home based on the contractual warranties and the one-year warranty set forth in Miss. Code Ann. § 83-58-5(1)(a) because the term "additional performance standards" in Miss. Code Ann. § 83-58-3(b) incorporated such matters that were set out in the contract, even though no violations of any building code were found. DiMa Homes, Inc. v. Stuart, 873 So. 2d 140, 2004 Miss. App. LEXIS 418 (Miss. Ct. App. 2004).

2. Limitations period.

Claim by homeowners against a builder under the New Home Warranty Act, Miss. Code Ann. § 83-58-1 et seq., for structural defects in the homeowners' home, was time-barred because (1) the claim had to be filed within six years of the home's first occupation, under Miss. Code Ann. §§ 83-58-5(1)(b), and 83-58-3(g), and (2) the home was first occupied over six years before suit was filed. Townes v. Rusty Ellis Builder, Inc., 98 So. 3d 1046, 2012 Miss. LEXIS 483 (Miss. 2012).

3. Builder.

Trial court properly granted summary judgment in favor of the sole member of a limited liability company (LLC) in homeowners' action alleging negligence and breach of warranty because the member was not personally liable for the defects in their home; the LLC was the builder of the home, not the member. Brown v. Waldron, 186 So. 3d 955, 2016 Miss. App. LEXIS 115 (Miss. Ct. App. 2016).

RESEARCH REFERENCES

ALR.

Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

Am. Jur.

77 Am. Jur. 2d, Vendor and Purchaser § 283.

§ 83-58-5. Builder's warranties to owner.

(1) Subject to the exclusions provided in this section, every builder warrants the following to the owner:

(a) One (1) year following the warranty commencement date, the home will be free from any defect due to noncompliance with the building standards.

(b) Six (6) years following the completion date, the home will be free from major structural defects due to noncompliance with the building standards.

(2) Unless the parties otherwise agree in writing, the builder's warranty shall exclude the following items:

(a) Defects in outbuildings including detached garages and detached carports, except outbuildings which contain the plumbing, electrical, heating, cooling or ventilation systems serving the home; swimming pools and other recreational facilities; driveways; walkways; patios; boundary walls; retaining walls; bulkheads; fences; landscaping, including sodding, seeding, shrubs, trees, and planting; off-site improvements including streets, roads, drainage and utilities or any other improvements not a part of the home itself.

(b) Damage to real property which is not part of the home covered by the warranty and which is not included in the purchase price of the home.

(c) Any damage to the extent it is caused or made worse by any of the following:

(i) Negligence, improper maintenance or improper operation by anyone other than the builder or any employee, agent or subcontractor of the builder.

(ii) Failure by anyone other than the builder or any employee, agent or subcontractor of the builder to comply with the warranty requirements of manufacturers of appliances, equipment or fixtures.

(iii) Any change, alteration or addition made to the home by anyone after the initial occupancy by the owner, except any change, alteration or addition performed by the builder, or any employee, agent, or subcontractor of the builder.

(iv) Dampness, condensation or other damage due to the failure of the owner to maintain adequate ventilation or drainage.

(d) Any loss or damage which the owner has not taken timely action to minimize.

(e) Any defect in, or any defect caused by, materials or work supplied by anyone other than the builder, or any employee, agent or subcontractor of the builder.

(f) Normal wear and tear or normal deterioration.

(g) Loss or damage which does not constitute a defect in the construction of the home by the builder, or any employee, agent or subcontractor of the builder.

(h) Loss or damage resulting from war, accident, riot and civil commotion, water escape, falling objects, aircraft, vehicles, acts of God, lightning, windstorm, hail, flood, mud slide, earthquake, volcanic eruption, wind-driven water and changes in the level of the underground water table which are not reasonably foreseeable.

(i) Insect damage and rotting of any kind.

(j) Mold or mold damage, except in cases where the builder's negligence was a proximate or contributing cause of the mold or mold damage.

(k) Any condition which does not result in actual physical damage to the home.

(*l*) Failure of the builder to complete construction of the home.

(m) Any defect not reported in writing by registered or certified mail to the builder or insurance company, as appropriate, prior to the expiration of the period of coverage of that defect plus thirty (30) days.

(n) Consequential damages.

(o) Any loss or damage to a home caused by soil conditions or soil movement if the home is constructed on land owned by the initial purchaser and the builder obtains a written waiver from the initial purchaser for any loss or damage caused by soil conditions or soil movement.

(p) Any defect in an electrical, plumbing, heating, air conditioning or similar fixture not manufactured by the builder for which the manufacturer provides a warranty regardless of duration.

(3) The provisions of this section establish minimum required warranties and shall not be waived by the owner or reduced by the builder, provided the home is a single-family dwelling to be occupied by an owner as his home.

HISTORY: Laws, 1997, ch. 465, § 3; Laws, 2004, ch. 567, § 1; Laws, 2012, ch. 405, § 2, eff from and after July 1, 2012.

Editor's Notes — Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

JUDICIAL DECISIONS

ANALYSIS

1. Builder liable.
2. Limitations period.

1. Builder liable.

Builder was liable to two owners for defects in a new home based on the contractual warranties and the one-year warranty set forth in Miss. Code Ann. § 83-58-5(1)(a) because the term “additional performance standards” in Miss. Code Ann. § 83-58-3(b) incorporated such matters that were set out in the contract, even though no violations of any building code were found. DiMa Homes, Inc. v. Stuart, 873 So. 2d 140, 2004 Miss. App. LEXIS 418 (Miss. Ct. App. 2004).

2. Limitations period.

Claim by homeowners against a builder under the New Home Warranty Act, Miss. Code Ann. § 83-58-1 et seq., for structural defects in the homeowners' home, was time-barred because (1) the claim had to be filed within six years of the home's first occupation, under Miss. Code Ann. §§ 83-58-5(1)(b), and 83-58-3(g), and (2) the home was first occupied over six years before suit was filed. Townes v. Rusty Ellis Builder, Inc., 98 So. 3d 1046, 2012 Miss. LEXIS 483 (Miss. 2012).

Claim by homeowners against a builder under the New Home Warranty Act (NHWA), Miss. Code Ann. § 83-58-1 et seq., was not subject to Miss. Code Ann. § 15-1-5 because the NHWA limitations period applied over the more general period in Miss. Code Ann. § 15-1-41. Townes v. Rusty Ellis Builder, Inc., 98 So. 3d 1046, 2012 Miss. LEXIS 483 (Miss. 2012).

RESEARCH REFERENCES

ALR.

Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

Am. Jur.

77 Am. Jur. 2d, Vendor and Purchaser § 283.

§ 83-58-7. Written notice of defect to builder.

Before undertaking any repair himself, except repair to minimize loss or damage as provided in Section 83-58-5(2)(d), or instituting any action under Section 83-58-17, the owner shall give the builder written notice within ninety (90) days after knowledge of the defect by registered or certified mail, advising him of the defects and giving the builder a reasonable opportunity to repair the defect. The builder shall give the owner written notice of the requirements of this chapter at the time of closing. If the builder does not provide such notice, the warranties provided in this chapter shall be extended for a period of time equal to the time between the warranty commencement date and date notice was given.

HISTORY: Laws, 1997, ch. 465, § 4; Laws, 2004, ch. 567, § 2, eff from and after July 1, 2004.

Editor's Notes — Laws of 1997, ch. 465, § 10 provides that:

“SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997.”

JUDICIAL DECISIONS

1. Notice given.

Builder was liable for damages resulting from a breach of warranty with regards to the construction of a new house because two owners complied with the Mississippi New Home Warranty Act, Miss. Code Ann. §§ 83-58-1 through 83-58-17, when they only filed suit after the builder failed to respond to their notice regarding many defects in the residence.

DiMa Homes, Inc. v. Stuart, 873 So. 2d 140, 2004 Miss. App. LEXIS 418 (Miss. Ct. App. 2004).

RESEARCH REFERENCES

ALR.
Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

Am. Jur.
77 Am. Jur. 2d, Vendor and Purchaser § 283.

§ 83-58-9. Commencement of warranty action.

Any action to enforce any warranty provided in this chapter shall commence thirty (30) days after the expiration of the appropriate time period provided.

HISTORY: Laws, 1997, ch. 465, § 5, eff from and after July 1, 1997.

Editor's Notes — Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

RESEARCH REFERENCES

ALR.
Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

Am. Jur.
77 Am. Jur. 2d, Vendor and Purchaser § 283.

§ 83-58-11. Insurance for warranty allegations.

All or part of the builder's obligation under any warranty required in this chapter may be insured by the builder for the benefit of the purchaser through an insurance company authorized to transact business in this state.

HISTORY: Laws, 1997, ch. 465, § 6, eff from and after July 1, 1997.

Editor's Notes — Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

RESEARCH REFERENCES

ALR.
Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

Am. Jur.
77 Am. Jur. 2d, Vendor and Purchaser § 283.

§ 83-58-13. Transfer of warranties.

Any warranty imposed under the provisions of this chapter and any insurance benefit shall automatically transfer, without charge, to a subsequent owner who acquires title to a home. Any transfer of the home shall not extend the duration of any warranty or insurance coverage.

HISTORY: Laws, 1997, ch. 465, § 7, eff from and after July 1, 1997.

Editor's Notes — Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

RESEARCH REFERENCES

ALR.
Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

Am. Jur.
77 Am. Jur. 2d, Vendor and Purchaser § 283.

§ 83-58-15. Damages; arbitration of claims.

The damages with respect to a single defect shall not exceed the reasonable cost of repair or replacement necessary to cure the defect, and damages with respect to all defects in the home shall not exceed the original purchase price of the home.

The parties may provide for the arbitration of any claim in dispute. Any arbitration may be binding only to the extent provided by law.

HISTORY: Laws, 1997, ch. 465, § 8, eff from and after July 1, 1997.

Editor's Notes — Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

JUDICIAL DECISIONS

1. Damages upheld.
Damages awarded in a case alleging breach of warranty, a breach of contract, and a breach of the implied duty of reasonably skilled workmanship in a construction contract were upheld on review because they did not exceed the amount of the purchase price, the "cost rule" method was appropriately used calculate the amount required to fix the defects in a new home, the award did not result in economic waste, and the amount awarded was not unreasonable or outrageous. DiMa Homes, Inc. v. Stuart, 873 So. 2d 140, 2004 Miss. App. LEXIS 418 (Miss. Ct. App. 2004).

RESEARCH REFERENCES

ALR.
Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

Recovery of punitive damages for breach of building or construction contract. 40 A.L.R.4th 110.

Am. Jur.
77 Am. Jur. 2d, Vendor and Purchaser § 283.

§ 83-58-17. Statutory remedy for damages arising from violations of home warranty law; common law remedies.

(1) If a builder violates any of the provisions of this chapter by failing to perform as required by the warranties provided in this chapter, any affected owner shall have a cause of action against the builder for actual damages, including attorney fees and court cost, arising out of the violations.

(2) Nothing in this chapter shall prevent the owner from filing a cause of action based on breach of contract and remedies attendant to such cause of action.

(3) If the owner files a civil action without first complying with the provisions of this chapter, the court shall dismiss the action without prejudice, and the action may not be refiled until the claimant has complied with the notice requirements of this chapter.

HISTORY: Laws, 1997, ch. 465, § 9; Laws, 2004, ch. 567, § 3, eff from and after July 1, 2004.

Editor's Notes — Laws of 1997, ch. 465, § 10 provides that:
"SECTION 10. This act shall take effect and be in force from and after July 1, 1997, and shall apply to new home warranties entered into on or after July 1, 1997."

JUDICIAL DECISIONS

ANALYSIS

1. Builder.
2. Breach of contract.

1. Builder.
It was undisputed that plaintiffs entered into a contract with the building corporation, not debtor, its sole owner. As a result, plaintiff was not entitled to relief from debtor under the New Home Warranty Act. Hoffmeister v. Early (In re Early), 2013 Bankr. LEXIS 4128 (Bankr. S.D. Miss. Sept. 30, 2013).

2. Breach of contract.
Trial court properly granted summary judgment in favor of the sole member of a limited liability company in homeowners' action alleging negligence and breach of warranty because the "Notice to Home Buyer of the New Home Warranty Act (NHWA)" was simply a form document setting out the provisions of the NHWA, and the Notice was not a contract; the NHWA anticipates the need for homeowners to file breach-of-contract claims in addition to breach-of-home-warranty claims. Brown v. Waldron, 186 So. 3d 955, 2016 Miss. App. LEXIS 115 (Miss. Ct. App. 2016).

RESEARCH REFERENCES

ALR.

Liability of builder-vendor or other builder of new dwelling for loss, injury or damage occasioned by defective condition thereof. 25 A.L.R.3d 383.

Am. Jur.

77 Am. Jur. 2d, Vendor and Purchaser § 283.

CHAPTER 59.

BUSINESS TRANSACTED WITH PRODUCER CONTROLLED INSURER ACT

Sec.
83-59-1. Short title.
83-59-3. Definitions.
83-59-5. Applicability to licensed insurers; effect of, and upon, other laws governing insurance holding companies.
83-59-7. When applicable; minimum requirements for contracts between controlled insurer and controlling producer; audits and reports.
83-59-9. Notification to insured of control relationship.
83-59-11. Enforcement; noncompliance; penalties.

§ 83-59-1. Short title.

This chapter may be cited as the "Business Transacted with Producer Controlled Insurer Act."

HISTORY: Laws, 1992, ch. 449, § 1, eff from and after July 1, 1992.

RESEARCH REFERENCES

ALR.
Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

Am. Jur.
43 Am. Jur. 2d, Insurance § 161.

§ 83-59-3. Definitions.

As used in this chapter:

(a) "Accredited state" means a state in which the insurance department or regulatory agency has qualified as meeting the minimum financial regulatory standards promulgated and established from time to time by the National Association of Insurance Commissioners (NAIC).

(b) "Commissioner" means the Commissioner of Insurance.

(c) "Control" or "controlled" has the meaning ascribed in Section 83-6-1.

(d) "Controlled insurer" means a licensed insurer which is controlled, directly or indirectly, by a producer.

(e) "Controlling producer" means a producer who, directly or indirectly, controls an insurer.

(f) "Licensed insurer" or "insurer" means any person, firm, association or corporation duly licensed to transact a property/casualty insurance business in this state. The following, inter alia, are not licensed insurers for the purposes of this chapter:

(i) All risk retention groups as defined in the Superfund Amendments Reauthorization Act of 1986, Public Law No. 99-499, 100 Stat. 1613 (1986) and the Risk Retention Act, 15 U.S.C.S. Section 3901 et seq. (1982 & Supp. 1986) and the State Risk Retention Act in Section 83-55-1 et seq.;

(ii) All residual market pools and joint underwriting authorities or associations;

(iii) All captive insurers that are insurance companies owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies or, in the case of groups and associations, insurance organizations owned by the insureds whose exclusive purpose is to insure risks to member organizations and/or group members and their affiliates; and

(iv) All insurers that are insurance companies owned by another organization whose property or casualty insurance policies are written only in conjunction with consumer loan contracts.

(g) "Producer" means an insurance broker or brokers or any other person, firm, association or corporation when, for any compensation, commission or other thing of value, such person, firm, association or corporation acts or aids in any manner in soliciting, negotiating or procuring the making of any insurance contract on behalf of an insured other than the person, firm, association or corporation.

HISTORY: Laws, 1992, ch. 449, § 2, eff from and after July 1, 1992.

Cross References — Application of chapter to licensed insurers as defined in this section, see § 83-59-5.

Federal Aspects — Superfund Amendments Reauthorization Act of 1986, see 42 USCS §§ 9601 et seq.

§ 83-59-5. Applicability to licensed insurers; effect of, and upon, other laws governing insurance holding companies.

This chapter shall apply to licensed insurers as defined in Section 83-59-3, either domiciled in this state or domiciled in a state that is not an accredited state having in effect a substantially similar law. All laws governing insurance holding companies to the extent they are not superseded by this chapter shall continue to apply to all parties within holding company systems subject to this chapter.

HISTORY: Laws, 1992, ch. 449, § 3, eff from and after July 1, 1992.

§ 83-59-7. When applicable; minimum requirements for contracts between controlled insurer and controlling producer; audits and reports.

(1) The provisions of this section shall apply if, in any calendar year, the aggregate amount of gross written premium on business placed with a controlled insurer by a controlling producer is equal to or greater than five percent (5%) of the admitted assets of the controlled insurer, as reported in the controlled insurers' quarterly statement filed as of September 30 of the prior year.

(2) Notwithstanding subsection (1) of this section, this section shall not apply if:

(a) The controlling producer:

(i) Places insurance only with the controlled insurer, or only with the controlled insurer and a member or members of the controlled insurer's holding company system, or the controlled insurer's parent, affiliate or subsidiary and receives no compensation based upon the amount of premiums written in connection with such insurance; and

(ii) Accepts insurance placements only from nonaffiliated subproducers and not directly from insureds; and

(b) The controlled insurer, except for insurance business written through a residual market facility, accepts insurance business only from a controlling producer, a producer controlled by the controlled insurer or a producer that is a subsidiary of the controlled insurer.

(3) A controlled insurer shall not accept business from a controlling producer and a controlling producer shall not place business with a controlled insurer unless there is a written contract between the controlling producer and the insurer specifying the responsibilities of each party, and the contract has been approved by the board of directors of the insurer and contains the following minimum provisions:

(a) The controlled insurer may terminate the contract for cause, upon written notice to the controlling producer. The controlled insurer shall suspend the authority of the controlling producer to write business during the pendency of any dispute regarding the cause for the termination;

(b) The controlling producer shall render accounts to the controlled insurer detailing all material transactions, including information necessary to support all commissions, charges and other fees received by, or owing to, the controlling producer;

(c) The controlling producer shall remit all funds due under the terms of the contract to the controlled insurer on at least a monthly basis. The due date shall be fixed so that premiums or installments thereof collected shall be remitted no later than ninety (90) days after the effective date of any policy placed with the controlled insurer under this contract;

(d) All funds collected for the controlled insurer's account shall be held by the controlling producer in a fiduciary capacity, in one or more appropriately identified bank accounts in banks that are members of the Federal Reserve System, in accordance with the provisions of the insurance law as applicable. However, funds of a controlling producer not required to be licensed in this state shall be maintained in compliance with the requirements of the controlling producer's domiciliary jurisdiction;

(e) The controlling producer shall maintain separately identifiable records of business written for the controlled insurer;

(f) The contract shall not be assigned in whole or in part by the controlling producer;

(g) The controlled insurer shall provide the controlling producer with its underwriting standards, rules and procedures, manuals setting forth the rates to be charged, and the conditions for the acceptance or rejection of risks. The controlling producer shall adhere to the standards, rules, procedures, rates and conditions. The standards, rules, procedures, rates and conditions shall be the same as those applicable to comparable business placed with the controlled insurer by a producer other than the controlling producer;

(h) The rates and terms of the controlling producer's commissions, charges or other fees and the purposes for those charges or fees. The rates of the commissions, charges and other fees shall be no greater than those applicable to comparable business placed with the controlled insurer by producers other than controlling producers. For purposes of this paragraph and paragraph (g) of this subsection, examples of "comparable business" include the same lines of insurance, same kinds of insurance, same kinds of risks, similar policy limits and similar quality of business;

(i) If the contract provides that the controlling producer, on insurance business placed with the insurer, is to be compensated contingent upon the insurer's profits on that business, then such compensation shall not be determined and paid until at least five (5) years after the premiums on liability insurance are earned and at least one (1) year after the premiums are earned on any other insurance. In no event shall the commissions be paid until the adequacy of the controlled insurer's reserves on remaining claims has been independently verified in accordance with subsection (4) of this section;

(j) A limit on the controlling producer's writings in relation to the controlled insurer's surplus and total writings. The insurer may establish a different limit for each line or subline of business. The controlled insurer shall notify the controlling producer when the applicable limit is approached and shall not accept business from the controlling producer if the limit is reached. The controlling producer shall not place business with the controlled insurer if it has been notified by the controlled insurer that the limit has been reached; and

(k) The controlling producer may negotiate but shall not bind reinsurance on behalf of the controlled insurer on business the controlling producer places with the controlled insurer, except that the controlling producer may bind facultative reinsurance contracts in accordance with obligatory facultative agreements if the contract with the controlled insurer contains underwriting guidelines including, for both reinsurance assumed and ceded, a list of reinsurers with which such automatic agreements are in effect, the coverages and amounts or percentages that may be reinsured and commission schedules.

(4) Every controlled insurer shall have an Audit Committee of the Board of Directors composed of independent directors. The Audit Committee shall annually meet with management, the insurer's independent certified public accountants and an independent casualty actuary or other independent loss reserve specialist acceptable to the commissioner to review the adequacy of the insurer's loss reserves.

(a) In addition to any other required loss reserve certification, the controlled insurer shall annually, on April 1 of each year, file with the commissioner an opinion of an independent casualty actuary, or such other independent loss reserve specialist acceptable to the commissioner, reporting loss ratios for each line of business written and attesting to the adequacy of loss reserves established for losses incurred and outstanding as of year-end (including incurred but not reported) on business placed by the producer; and

(b) The controlled insurer shall annually report to the commissioner the amount of commissions paid to the producer, the percentage such amount represents of the net premiums written and comparable amounts and percentage paid to noncontrolling producers for placements of the same kinds of insurance.

HISTORY: Laws, 1992, ch. 449, § 4, eff from and after July 1, 1992.

Editor's Notes — Laws of 1992, ch. 449, § 7, effective from and after July 1, 1992, provides as follows:

"SECTION 7. Controlled insurers and controlling producers who are not in compliance with Section 83-59-7 on July 1, 1992, shall have sixty (60) days to come into compliance and shall comply with Section 83-59-9 beginning with all policies written or renewed on or after September 1, 1992."

§ 83-59-9. Notification to insured of control relationship.

The producer, before the effective date of the policy, shall deliver written notice to the prospective insured disclosing the relationship between the producer and the controller insurer; except that, if the business is placed through a subproducer who is not a controlling producer, the controlling producer shall retain in his records a signed commitment from the subproducer that the subproducer is aware of the relationship between the insurer and the producer and that the subproducer has or will notify the insured.

HISTORY: Laws, 1992, ch. 449, § 5, eff from and after July 1, 1992.

Editor's Notes — Laws of 1992, ch. 449, § 7, effective from and after July 1, 1992, provides as follows:

"SECTION 7. Controlled insurers and controlling producers who are not in compliance with Section 83-59-7 on July 1, 1992, shall have sixty (60) days to come into compliance and shall comply with Section 83-59-9 beginning with all policies written or renewed on or after September 1, 1992."

RESEARCH REFERENCES

ALR.

Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

Am. Jur.

43 Am. Jur. 2d, Insurance § 161.

§ 83-59-11. Enforcement; noncompliance; penalties.

(1)(a) If the commissioner believes that the controlling producer or any other person has not materially complied with this chapter, or any regulation or order promulgated hereunder, after notice and opportunity to be heard, the commissioner may order the controlling producer to cease placing business with the controlled insurer; and

(b) If it was found that because of such material noncompliance that the controlled insurer or any policyholder thereof has suffered any loss or damage, the commissioner may maintain a civil action or intervene in an action brought by or on behalf of the insurer or policyholder for recovery of compensatory damages for the benefit of the insurer or policyholder or other appropriate relief.

(2) If an order for liquidation or rehabilitation of the controlled insurer has been entered in accordance with the Insurers Rehabilitation and Liquidation Act in Section 83-24-1 et seq. and the receiver appointed under that order believes that the controlling producer or any other person has not materially complied with this chapter, or any regulation or order promulgated hereunder, and the insurer suffered any loss or damage therefrom, the receiver may maintain a civil action for recovery of damages or other appropriate sanctions for the benefit of the insurer.

(3) Nothing contained in this section shall affect the right of the commissioner to impose any other penalties provided for in the insurance laws.

(4) Nothing contained in this section is intended to or shall in any manner alter or affect the rights of policyholders, claimants, creditors or other third parties.

HISTORY: Laws, 1992, ch. 449, § 6, eff from and after July 1, 1992.

RESEARCH REFERENCES

ALR.

Public regulation or control of insurance agents or brokers. 10 A.L.R.2d 950.

Am. Jur.

43 Am. Jur. 2d, Insurance § 161.

CHAPTER 61.

VOLUNTARY BASIC HEALTH INSURANCE COVERAGE LAW

Sec.	
83-61-1.	Short title.
83-61-3.	Definitions.
83-61-5.	Promulgation of rules and regulations.
83-61-7.	Eligibility.
83-61-9.	Participation voluntary.
83-61-11.	Exemption from mandated benefits and premium tax.
83-61-13.	Written disclosure by the carrier; written statement by eligible individual; services and costs information.
83-61-15.	Advisory committee; membership.
83-61-17.	Filing of rates.
83-61-19.	Minimum loss ratio.

§ 83-61-1. Short title.

This chapter shall be known and may be cited as the "Voluntary Basic Health Insurance Coverage Law."

HISTORY: Laws, 1992, ch. 578, § 1; reenacted without change, Laws, 1994, ch. 620, § 1, eff from and after July 1, 1994.

Editor's Notes — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

§ 83-61-3. Definitions.

As used in this chapter the following words and phrases shall have the meanings ascribed herein unless the context clearly requires otherwise:

(a) "Carrier" means any insurance company, health maintenance association or hospital, medical or surgical services association that is authorized by the State of Mississippi to write accident and health insurance policies and contracts.

(b) "Program" means the Voluntary Basic Health Insurance Coverage Program.

(c) "Provider" means any provider of medical services as defined in the contract of insurance coverage.

(d) "Approved carrier" means any insurance company, health maintenance association or hospital, medical or surgical services association that meets the criteria established by this chapter to participate in the Voluntary Basic Health Insurance Coverage Program.

HISTORY: Laws, 1992, ch. 578, § 2; reenacted without change, Laws, 1994, ch. 620, § 2, eff from and after July 1, 1994.

Editor's Notes — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

§ 83-61-5. Promulgation of rules and regulations.

The Commissioner of Insurance is directed to promulgate rules and regulations to establish procedures for implementation of the provisions of this chapter and penalties for noncompliance.

HISTORY: Laws, 1992, ch. 578, § 3; reenacted without change, Laws, 1994, ch. 620, § 3, eff from and after July 1, 1994.

Editor's Notes — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

§ 83-61-7. Eligibility.

(1) To be eligible for insurance coverage under the program, an individual shall provide evidence to the approved carrier that he or she:

(a) Is under sixty-five (65) years of age;

(b) Is acceptable to the approved carrier; and

(c) Has been without private health insurance coverage for the twelve (12) months immediately preceding application to the program, or that his or her family income does not exceed one hundred fifty percent (150%) of the federal poverty level.

(2) No person who is covered under the program and terminates the coverage is again eligible for coverage unless twelve (12) months have elapsed since the person's latest termination.

HISTORY: Laws, 1992, ch. 578, § 4; reenacted without change, Laws, 1994, ch. 620, § 4, eff from and after July 1, 1994.

Editor's Notes — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of , 1992, ch. 578, § 13.

Cross References — Required certification by individual of eligibility, see § 83-61-13.

§ 83-61-9. Participation voluntary.

Participation by carriers and providers in policy authorization by this chapter shall be voluntary.

HISTORY: Laws, 1992, ch. 578, § 5; reenacted without change, Laws, 1994, ch. 620, § 5, eff from and after July 1, 1994.

Editor's Notes — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

§ 83-61-11. Exemption from mandated benefits and premium tax.

Contracts of insurance coverage offered by approved carriers that are approved by the Commissioner of Insurance shall be exempt from all state mandated benefits and from the premium tax required in Sections 27-15-103 and 27-15-109.

HISTORY: Laws, 1992, ch. 578, § 6; reenacted without change, Laws, 1994, ch. 620, § 6, eff from and after July 1, 1994.

Editor's Notes — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

Cross References — Premium taxes on foreign insurance companies, see § 27-15-103.

Premium taxes on domestic insurance companies, see § 27-15-109.

§ 83-61-13. Written disclosure by the carrier; written statement by eligible individual; services and costs information.

(1) Upon offering coverage under a minimum benefits or basic coverage contract issued in accordance with this chapter, the approved carrier shall provide the eligible individual with a written disclosure containing at least the following:

(a) An explanation that this is a minimum benefits or basic insurance coverage contract and that benefits otherwise mandated by state law are not covered in the minimum benefits contracts;

(b) An explanation of the benefits mandated by state law;

(c) An explanation of the cost control features of the minimum benefits or basic coverage contract; and

(d) A list of applicable addresses and telephone numbers for use by the eligible individual to obtain information on and authorization for participation in the program.

(2) Before issuing a minimum benefits or basic insurance coverage contract in accordance with this chapter, the approved carrier shall obtain from the eligible individual a signed written statement in which the individual:

(a) Certifies his or her eligibility for coverage under a minimum benefits or basic coverage contract in accordance with Section 83-61-7;

(b) Acknowledges the limited benefits provided under the basic coverage insurance contract.

(3) The State Health Department shall furnish information to approved carriers concerning the services, and the costs of such services, if any, available from the county and state health departments, and such information shall be included in contracts of insurance coverage.

(4) The carriers shall furnish information to their policyholders concerning the federal government's earned income credit for health insurance, and

such information shall be included in contracts of insurance coverage issued under this chapter.

HISTORY: Laws, 1992, ch. 578, § 7; reenacted without change, Laws, 1994, ch. 620, § 7, eff from and after July 1, 1994.

Editor's Notes — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

§ 83-61-15. Advisory committee; membership.

The Commissioner of Insurance may appoint an advisory committee, engage consultants or participate in grant programs to study and recommend the details of the program. The advisory committee shall be composed of the following: one (1) physician, one (1) hospital representative, one (1) small business representative, one (1) domestic insurer, one (1) member of the Health Insurance Agents Association, and one (1) nonprofit insurer. One (1) representative of the Department of Insurance shall serve as an ex officio member of the advisory committee. The advisory committee shall serve at the will and pleasure of the Commissioner of Insurance.

HISTORY: Laws, 1992, ch. 578, § 8; reenacted without change, Laws, 1994, ch. 620, § 8, eff from and after July 1, 1994.

Editor's Notes — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

§ 83-61-17. Filing of rates.

The Commissioner of Insurance may require carriers to file rates for informational purposes. Nothing in this chapter shall be construed to require the commissioner's approval before using such rates.

HISTORY: Laws, 1992, ch. 578, § 9; reenacted without change, Laws, 1994, ch. 620, § 9, eff from and after July 1, 1994.

Editor's Notes — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

§ 83-61-19. Minimum loss ratio.

The Commissioner of Insurance may require a minimum loss ratio that carriers must meet in order to participate in the program.

HISTORY: Laws, 1992, ch. 578, § 10; reenacted without change, Laws, 1994, ch. 620, § 10, eff from and after July 1, 1994.

Editor's Notes — Laws of 1992, ch. 578, § 13, provided for the repeal of this section effective from and after July 1, 1994. Subsequently, Laws of 1994, ch. 620, § 13, repealed Laws of 1992, ch. 578, § 13.

CHAPTER 62.

HEALTH SAVINGS ACCOUNTS

Sec.	
83-62-1.	Short title.
83-62-3.	Definitions.
83-62-5.	Contributions to health savings account; exemption from taxable gross income.
83-62-7.	Purposes for which trustee may utilize funds.
83-62-9.	Withdrawal of money; disbursement of account assets pursuant to a filing for protection under Bankruptcy Code; transfer of interest in account to spouse under divorce or separation agreement; distribution upon death of eligible individual; transfer upon change of employment.

§ 83-62-1. Short title.

This chapter shall be known and may be cited as the "Health Savings Accounts Act."

HISTORY: Laws, 2005, ch. 484, § 1, eff from and after Jan. 1, 2005.

§ 83-62-3. Definitions.

As used in this chapter:

(a) "Eligible individual" means the individual taxpayer, including employees of an employer who contributes to health savings accounts on the employees' behalf, who:

(i) Is covered by a high deductible health plan individually or with his or her dependents as defined in this chapter;

(ii) Is not covered under any health plan that is not a high deductible health plan, except for coverage for accidents, disability, dental care, vision care, long-term care, workers' compensation insurance, insurance for a specified disease or illness, insurance paying a fixed amount per day per hospitalization and coverage for tort liabilities or liabilities relating to ownership or use of property; and

(iii) Establishes, or on whose behalf is established, a health savings account.

(b) "Deductible" means the total deductible for an eligible individual and all the dependents of that eligible individual for a calendar year.

(c) "Dependent" means the spouse or child of the eligible individual as defined in Section 152 of the Internal Revenue Code subject to any additional modifications imposed by Section 223(d) (2) of the Internal Revenue Code.

(d) "Qualified medical expense" means an expense paid by the taxpayer for medical care described in Section 213(d) of the Internal Revenue Code.

(e) "High deductible health plan" means a health plan with:

(i) In the case of self-only coverage, an annual deductible which is not less than One Thousand Dollars ($1,000.00) and the sum of the annual deductible and other annual out-of-pocket expenses required to be paid under the plan for covered benefits does not exceed Five Thousand One Hundred Dollars ($5,100.00).

(ii) In the case of family coverage, an annual deductible of not less than Two Thousand Dollars ($2,000.00) and the sum of the annual deductible and other annual out-of-pocket expenses required to be paid under the plan for covered benefits does not exceed Ten Thousand Two Hundred Dollars ($10,200.00).

(iii) The minimum annual deductible amounts and maximum annual out-of-pocket expense limits may be adjusted each year according to a cost-of-living adjustment as determined under Section 223(g) of the Internal Revenue Code.

(iv) A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care, or in the case of network plans, for having limits for out-of-pocket expenses or annual deductibles for services provided outside the network that exceed the limitations in this section.

(f) "Health savings account" or "account" means a trust or custodian established in this state pursuant to a health savings account program exclusively to pay the qualified medical expenses of an eligible individual or his or her dependents, but only if the written governing instrument creating the account meets the following requirements:

(i) Except in the case of a rollover contribution, no contribution will be accepted unless it is in cash; or, to the extent such contribution, when added to the previous contributions to the account for the calendar year, exceeds one hundred percent (100%) of the eligible individual's deductible or Two Thousand Six Hundred Fifty Dollars ($2,650.00) for an individual or Five Thousand Two Hundred Fifty Dollars ($5,250.00) per family, whichever is lower;

(ii) The trustee or custodian is a bank, an insurance company or another person approved by the United States Department of Treasury and the Commissioner of Insurance;

(iii) No part of the trust assets will be invested in life insurance contracts;

(iv) The assets of the account will not be commingled with other property except as allowed for under Individual Retirement Accounts; and

(v) The eligible individual's interest in the account is nonforfeitable.

The maximum dollar amounts in this paragraph may be adjusted each year according to a cost-of-living adjustment as determined under Section 223(g) of the Internal Revenue Code.

Eligible individuals who have attained age fifty-five (55) before the end of the year may make additional catch-up contributions into the account in the amount determined in accordance with the following table:

2005	$ 600.00
2006	$ 700.00
2007	$ 800.00

2008	$ 900.00
2009 and thereafter	$1,000.00

(g) "Health savings account program" or "program" means a program that includes all of the following:

(i) The purchase by an eligible individual or by an employer of a high deductible health plan; and

(ii) The contribution into a health savings account by or on behalf of an eligible individual or on behalf of an employee by his or her employer. The total annual contribution may not exceed the amount of the plan's higher deductible or the amounts listed herein.

HISTORY: Laws, 2005, ch. 484, § 2, eff from and after Jan. 1, 2005.

Federal Aspects — Sections 152, 213(d) and 223(d)(2) and (g) of the Internal Revenue Code, see 26 USCS §§ 152, 213(d) and 223(d)(2) and (g), respectively.

§ 83-62-5. Contributions to health savings account; exemption from taxable gross income.

(1) For taxable years beginning after January 1, 2005, contributions may be made into a health savings account by or on behalf of a resident of Mississippi pursuant to Section 83-62-3(f).

(2) Except as provided in Section 83-62-9, or except as otherwise provided by law, the principal contributed to and the interest earned on a health savings account and money reimbursed to an eligible individual or an employee for qualified medical expenses shall be excluded from the taxable gross income of the account holder under Section 27-7-15.

HISTORY: Laws, 2005, ch. 484, § 3, eff from and after Jan. 1, 2005.

§ 83-62-7. Purposes for which trustee may utilize funds.

The trustee or custodian shall utilize the funds held in a health savings account solely for the purpose of:

(a) Paying the qualified medical expenses of the eligible individual or his or her dependents;

(b) Purchasing a health coverage policy certificate, or contract, for an eligible individual who is receiving unemployment compensation, is exercising continuation privileges under federal law or is purchasing a long-term care insurance contract; or

(c) Paying for health insurance other than a Medicare supplemental policy for those who are Medicare eligible. Funds held in a health savings account shall not be used to cover expenses of the eligible individual or his or her dependents that are otherwise covered, including, but not limited to, medical expense covered pursuant to an automobile insurance policy, workers' compensation insurance policy or self-insured plan or another employer-funded health coverage policy, certificate or contract.

HISTORY: Laws, 2005, ch. 484, § 4, eff from and after Jan. 1, 2005.

§ 83-62-9. Withdrawal of money; disbursement of account assets pursuant to a filing for protection under Bankruptcy Code; transfer of interest in account to spouse under divorce or separation agreement; distribution upon death of eligible individual; transfer upon change of employment.

(1) Notwithstanding subsection (3), (4), (5) or (6) of this section, an eligible individual may withdraw money from his or her health savings account for any purpose other than a purpose described in Section 83-62-7.

(2) Subject to subsection (3) of this section, if the eligible individual withdraws money for any purpose other than a purpose described in Section 83-62-7 at any other time, all of the following apply:

(a) The amount of the withdrawal is considered taxable gross income of the account holder under Section 27-7-15 in the tax year of the withdrawal.

(b) Interest earned on the account during the tax year in which a withdrawal under this subsection is made is considered taxable gross income of the account holder under Section 27-7-15.

(3) The amount of disbursement of any assets of a health savings account pursuant to a filing for protection under Title 11 of the United States Code, 11 USCS 101 et seq., by an eligible individual or person for whose benefit the account was established is not considered a withdrawal for purposes of this section. The amount of a disbursement is not considered taxable gross income of the account holder under Section 27-7-15 and subsection (2) of this section does not apply.

(4) The transfer of an eligible individual's interest in a health savings account to an eligible individual's spouse or former spouse under a divorce or separation instrument shall not be considered a taxable transfer made by such eligible individual, and such interest shall, after such transfer, be treated as a health savings account with respect to which such spouse is the eligible individual.

(5) Upon the death of the eligible individual, the trustee or custodian shall distribute the principal and accumulated interest of the health savings account to the estate of the deceased.

(6) If an employee becomes employed with a different employer that participates in a health savings account program, the employee may transfer his or her health savings account to that new employer's trustee or custodian or to an individually purchased account program.

HISTORY: Laws, 2005, ch. 484, § 5, eff from and after Jan. 1, 2005.

CHAPTER 63.

SMALL EMPLOYER HEALTH BENEFIT PLANS

Sec.

83-63-1. Application of chapter.
83-63-3. Definitions.
83-63-5. Limitation on establishment of classes of business by small employer carriers.
83-63-6. Requirements for small employer carriers.
83-63-7. Procedures for premium rates and restrictions on premium rate increases; authority to establish regulations; restrictions on transfers or offers to transfer small employer into or out of class of business; suspension of application of index rate provision.
83-63-9. Disclosure requirements for solicitation and sales material for sale of health benefit plan; maintenance of description of rating practices and renewal underwriting practices; actuarial certification requirements; access to information and documentation by commissioner; confidentiality of information.
83-63-11. Renewal of health benefit plan at option of small employer; exceptions; right of carrier to cease to renew all plans under a class of business; restrictions; application of section to carrier operating in single geographic area.

§ 83-63-1. Application of chapter.

(1) This chapter shall apply to any health benefit plan that provides coverage to the employees of a small employer in this state if any of the following conditions are met:

(a) Any portion of the premium or benefits is paid by or on behalf of the small employer;

(b) An eligible employee or dependent is reimbursed, whether through wage adjustments or otherwise, by or on behalf of the small employer for any portion of the premium; or

(c) The health benefit plan is treated by the employer or any of the eligible employees or dependents as part of a plan or program for the purposes of Section 162, Section 125 or Section 106 of the United States Internal Revenue Code.

(2) This chapter shall not apply to an employer whose only role is collecting through payroll deduction the premiums of individual policies on behalf of employees.

HISTORY: Laws, 1994, ch. 302, § 1, eff from and after January 1, 1995.

Federal Aspects — Sections 106, 125, and 162 of the United States Internal Revenue Code, see 26 USCS §§ 106, 125, and 162.

§ 83-63-3. Definitions.

For purposes of this chapter, the following terms are defined as follows:

(a) "Actuarial certification" means a written statement by a member of the American Academy of Actuaries, or other individual acceptable to the commissioner, that a small employer carrier is in compliance with Section 83-63-7, based upon the person's examination, including a review of the appropriate records and of the actuarial assumptions and methods used by the small employer carrier in establishing premium rates for applicable health benefit plans.

(b) "Base premium rate" means for each class of business as to a rating period, the lowest premium rate charged or which could have been charged under the rating system for that class of business, by the small employer carrier to small employers with similar case characteristics for health benefit plans with the same or similar coverage.

(c) "Carrier" means any entity that provides health insurance in this state such as an insurance company; a prepaid hospital or medical service plan; a nonprofit hospital, medical and surgical service corporation; a health maintenance organization; a fully insured multiple employer welfare arrangement; or any other entity providing a plan of health insurance subject to state insurance regulation.

(d) "Case characteristics" means demographic or other objective characteristics of a small employer that are considered by the small employer carrier in the determination of premium rates for the small employer, but claim experience, health status and duration of coverage are not case characteristics for the purposes of this chapter.

(e) "Class of business" means all or a separate grouping of small employers established pursuant to Section 83-63-5.

(f) "Commissioner" means the Commissioner of Insurance.

(g) "Eligible employee" means an employee who works on a full-time basis and has a normal work week of thirty-two (32) or more hours. The term includes a sole proprietor, a partner of a partnership and an independent contractor, if the sole proprietor, partner or independent contractor is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a part-time, temporary or substitute basis.

(h) "Established geographic service area" means a geographical area, as approved by the commissioner and based on the carrier's certificate of authority to transact insurance in this state, within which the carrier is authorized to provide coverage.

(i) "Health benefit plan" or "plan" means any hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan does not include accident-only, specified disease, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance; coverage issued as a supplement to liability insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

(j) "Index rate" means for each class of business for small employees with similar case characteristics, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate.

(k) "New business premium rate" means for each class of business as to a rating period, the premium rate charged or offered by the small employer carrier to small employers with similar case characteristics for newly issued health benefit plans with the same or similar coverage.

(*l*) "Rating period" means the calendar period for which premium rates established by a small employer carrier are assumed to be in effect.

(m) "Small employer" means any person, firm, corporation, partnership or association actively engaged in business which, on at least fifty percent (50%) of its working days during the preceding year, employed no more than fifty (50) eligible employees. In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation shall be considered one (1) employer.

(n) "Small employer carrier" means any carrier which offers health benefit plans covering eligible employees of one or more small employers in this state.

HISTORY: Laws, 1994, ch. 302, § 2; Laws, 1997, ch. 341, § 1, eff from and after passage (approved from and after March 17, 1997).

§ 83-63-5. Limitation on establishment of classes of business by small employer carriers.

(1) A small employer carrier may establish a class of business only to reflect substantial differences in expected claims experience or administrative costs related to the following reasons:

(a) The small employer carrier uses more than one (1) type of system for the marketing and sale of health benefit plans to small employers;

(b) The small employer carrier has acquired a class of business from another small employer carrier; or

(c) The small employer carrier provides coverage through an association with membership of not less than twenty-five (25) small employers which has been formed for purposes other than obtaining insurance.

(2) A small employer carrier may establish up to nine (9) separate classes of business under subsection (1).

(3) The commissioner may establish regulations to provide for a period of transition in order for a small employer carrier to come into compliance with subsection (2) in the instance of acquisition of an additional class of business from another small employer carrier.

(4) The commissioner may approve the establishment of additional classes of business upon application to the commissioner and a finding by the commissioner that such action would enhance the efficiency and fairness of the small employer marketplace.

HISTORY: Laws, 1994, ch. 302, § 3, eff from and after January 1, 1995.

Cross References — "Class of business" as meaning all or a separate grouping of small employers established pursuant to this section, see § 83-63-3.

§ 83-63-6. Requirements for small employer carriers.

Any small employer carrier shall issue any health benefit plan to any small employer that applies for the plan and agrees to make the required premium payments and to satisfy the other reasonable provisions of the health benefit plan not inconsistent with this chapter. However, no carrier is required to issue a health benefit plan to a self-employed individual who is covered by, or is eligible for coverage under, a health benefit plan offered by an employer.

HISTORY: Laws, 1997, ch. 341, § 2, eff from and after passage (approved March 17, 1997).

§ 83-63-7. Procedures for premium rates and restrictions on premium rate increases; authority to establish regulations; restrictions on transfers or offers to transfer small employer into or out of class of business; suspension of application of index rate provision.

(1) Premium rates for health benefit plans subject to this chapter shall be subject to the following provisions:

(a) The index rate for a rating period for any class of business shall not exceed the index rate for any other class of business by more than twenty percent (20%).

(b) For a class of business, the premium rates charged during a rating period to small employers with similar case characteristics for the same or similar coverage, or the rates that could be charged to such employers under the rating system for that class of business, shall not vary from the index rate by more than twenty-five percent (25%) of the index rate.

(c) The percentage increase in the premium rate charged to a small employer for a new rating period may not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate;

(ii) Any adjustment, not to exceed fifteen percent (15%) annually and adjusted pro rata for rating periods of less than one (1) year, due to the claim experience, health status or duration of coverage of the employees or dependents of the small employer as determined from the small employer carrier's rate manual for the class of business; and

(iii) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the small employer carrier's rate manual for the class of business.

(d) Adjustments in rates for claim experience, health status and duration of coverage shall not be charged to individual employees or dependents. Any such adjustment shall be applied uniformly to the rates charged for all employees and dependents of the small employer.

(e) In the case of health benefit plans issued prior to January 1, 1995, a premium rate for a rating period may exceed the ranges set forth in paragraphs (a) and (b) of this subsection until January 1, 1996. In such case, the percentage increase in the premium rate charged to a small employer in such a class of business for a new rating period shall not exceed the sum of the following:

(i) The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period. In the case of a class of business into which the small employer carrier is no longer enrolling new small employers, the small employer carrier shall use the percentage change in the base premium rate;

(ii) Any adjustment due to change in coverage or change in the case characteristics of the small employer, as determined from the carrier's rate manual for the class of business; and

(iii) Any adjustment needed to bring the premium rate of a small employer to the base premium rate for that class of business.

(f) If an employer not meeting the definition of "small employer" on the date of issue or last renewal of its plan falls within such definition on a subsequent renewal date, and its premium rate is less than the base premium rate for the small employer class of business into which it is assigned, the employer's rate shall be the base premium rate for that class of business.

(g) Nothing in this section is intended to affect the use by a small employer carrier of legitimate rating factors other than claim experience, health status or duration of coverage in the determination of premium rates. Small employer carriers shall apply rating factors, including case characteristics, consistently with respect to all small employers in a class of business.

(h) The commissioner may establish regulations to implement the provisions of this section and to assure that rating practices used by small employer carriers are consistent with the purposes of this chapter, including:

(i) Assuring that differences in rates charged for health benefit plans by small employer carriers are reasonable and reflect objective differences in plan design, not including differences due to the nature of the groups assumed to select particular health benefit plans; and

(ii) Prescribing the manner in which case characteristics may be used by small employer carriers.

(2) A small employer carrier shall not transfer a small employer involuntarily into or out of a class of business. A small employer carrier shall not offer to transfer a small employer into or out of a class of business unless such offer is made to transfer all small employers in the class of business without regard to case characteristics, claim experience, health status or duration of coverage.

(3) The commissioner may suspend for a specified period the application of subsection (1)(a) as to the premium rates applicable to one or more small employers included within a class of business of a small employer carrier for one or more rating periods upon a filing by the small employer carrier and a finding by the commissioner either that the suspension is reasonable in light of the financial condition of the small employer carrier or that the suspension

would enhance the efficiency and fairness of the marketplace for small employer health insurance.

HISTORY: Laws, 1994, ch. 302, § 4, eff from and after January 1, 1995.

Cross References — "Actuarial certification" as meaning statement that small employer carrier is in compliance with this section, see § 83-63-3.

§ 83-63-9. Disclosure requirements for solicitation and sales material for sale of health benefit plan; maintenance of description of rating practices and renewal underwriting practices; actuarial certification requirements; access to information and documentation by commissioner; confidentiality of information.

(1) In connection with the offering for sale of any health benefit plan to a small employer, a small employer carrier shall make a reasonable disclosure, as part of its solicitation and sales materials, of all of the following:

(a) The extent to which premium rates for a specified small employer are established or adjusted based upon the actual or expected variation in claims costs or actual or expected variation in health status of the employees of the small employer and their dependents;

(b) The provisions of the health benefit plan concerning the small employer carrier's right to change premium rates and factors, other than claim experience, that affect changes in premium rates;

(c) A description of the class of business in which the small employer is or will be included, including the applicable grouping of plans;

(d) The provisions relating to renewability of policies and contracts; and

(e) The provisions relating to any pre-existing condition provision.

(2) Each small employer carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation that demonstrate that its rating methods and practices are based upon commonly accepted actuarial assumptions and are in accordance with sound actuarial principles.

(3) Each small employer carrier shall file with the commissioner annually on or before March 15, an actuarial certification certifying that the carrier is in compliance with this chapter and that the rating methods of the small employer carrier are actuarially sound. Such certification shall be in a form and manner, and shall contain such information, as specified by the commissioner. A copy of the certification shall be retained by the small employer carrier at its principal place of business.

(4) A small employer carrier shall make the information and documentation described in subsection (2) available to the commissioner upon request. Except in cases of violations of this chapter, the information shall be considered proprietary and trade secret information and shall not be subject to disclosure by the commissioner to persons outside of the department except as

agreed to by the small employer carrier or as ordered by a court of competent jurisdiction.

HISTORY: Laws, 1994, ch. 302, § 5, eff from and after January 1, 1995.

§ 83-63-11. Renewal of health benefit plan at option of small employer; exceptions; right of carrier to cease to renew all plans under a class of business; restrictions; application of section to carrier operating in single geographic area.

(1) A health benefit plan subject to this chapter shall be renewable with respect to all eligible employees and dependents, at the option of the small employer, except in any of the following cases:

(a) Nonpayment of the required premiums;

(b) Fraud or misrepresentation of the small employer, or with respect to coverage of individual insureds, the insureds or their representatives;

(c) Noncompliance with the carrier's minimum participation requirements;

(d) Noncompliance with the carrier's employer contribution requirements;

(e) Repeated misuse of a provider network provision; or

(f) The commissioner finds that the continuation of the coverage would:

(i) Not be in the best interests of the policyholders or certificate holders; or

(ii) Impair the carrier's ability to meet its contractual obligations.

In such instance the commissioner shall assist affected small employers in finding replacement coverage.

(2) A small employer carrier may cease to renew all plans under a class of business. The carrier shall provide notice to all affected health benefit plans and to the Commissioner of Insurance in each state in which an affected insured individual is known to reside at least one hundred eighty (180) days prior to termination of coverage. A carrier which exercises its rights to cease to renew all plans in a class of business shall not:

(a) Establish a new class of business for a period of five (5) years after the nonrenewal of the plans without prior approval of the Commissioner of Insurance; or

(b) Transfer or otherwise provide coverage to any of the employers from the nonrenewed class of business unless the carrier offers to transfer or provide coverage to all affected employers and eligible employees and dependents without regard to case characteristics, claim experience, health status or duration of coverage.

(3) In the case of a small employer carrier doing business in one (1) established geographic service area of the state, the rules set forth in this section shall apply only to the carrier's operations in such service area.

HISTORY: Laws, 1994, ch. 302, § 6, eff from and after January 1, 1995.

RESEARCH REFERENCES

Am. Jur.

43 Am. Jur. 2d, Insurance §§ 388-391.

CHAPTER 64.

HEALTH DISCOUNT PLANS

Sec.
83-64-1. Health discount plan; disclosures to and rights of consumer; Commissioner of Insurance authorized to adopt rules and regulations to implement provisions; applicability.

§ 83-64-1. Health discount plan; disclosures to and rights of consumer; Commissioner of Insurance authorized to adopt rules and regulations to implement provisions; applicability.

(1) "Health discount plan" means a card, program, device, arrangement, contract or mechanism that purports to offer discounts or access to discounts on health care services or supplies that is not insurance or that does not provide coverage for services or benefits regulated under Section 83-9-1 et seq.

(2) A person may not sell, market, promote, advertise or otherwise distribute a health discount plan unless:

(a) Each advertisement, policy, document, information, statement or other communication regarding the health discount plan and the plan itself contain a statement, in bold and prominent type, that the health discount plan is not insurance;

(b) The discounts offered under the health discount plan are specifically authorized by a contract with each provider of the services or supplies listed in conjunction with the plan;

(c) The health discount plan states the name, address and telephone number of the administrator of the plan;

(d) The person makes readily available to the consumer a complete, accurate and up-to-date list of providers participating in the plan that offers discounted health care services or supplies in the consumer's local area and the discounts offered by the providers;

(e) The person provides the consumer the right to cancel the health discount plan within thirty (30) days after purchase of the plan; and

(f) The person provides the consumer with a full refund of all payments made, except for a nominal processing fee, within thirty (30) days after notification of cancellation of the plan under paragraph (e) of this subsection.

(3) The Commissioner of Insurance may adopt regulations to implement this section and to establish additional requirements intended to prohibit unfair or deceptive practices relating to health discount plans.

(4) Rebates and discounts for health discount plans shall not apply to manufacturers of pharmaceuticals or supplies. This section shall not apply to the Division of Medicaid and shall not apply to pharmaceutical manufacturer discount cards.

HISTORY: Laws, 2007, ch. 553, § 7; Laws, 2010, ch. 419, § 1; Laws, 2013, ch. 316, § 1, eff from and after July 1, 2013.

CHAPTER 65.

REGULATION OF VEHICLE SERVICE CONTRACTS

Sec.
83-65-101. Purpose.
83-65-103. Definitions.
83-65-105. Issuance, sale, or offer for sale of service contract; authorized providers.
83-65-107. Issuance, sale, or offer for sale of service contract; document filing requirements; rates.
83-65-109. Issuance, sale, or offer for sale of reimbursement insurance policy.
83-65-111. Issuance, sale, or offer for sale of service contract; form and terms of contract.
83-65-113. Use of particular words in names of providers, contracts or literature; false or misleading statements or omissions, etc., by providers; requirement of purchase of vehicle service contract as condition of loan or sale.
83-65-115. Recordkeeping requirements.
83-65-117. Cancellation of reimbursement insurance policy.
83-65-119. Complaint against providers.
83-65-121. Promulgation of regulations.
83-65-123. Application of chapter.
83-65-125. Provider not required to be named insured under reimbursement insurance policy under certain circumstances.

§ 83-65-101. Purpose.

The sole purpose of this chapter is to provide for the regulation of vehicle service contracts. This chapter does not apply to motor vehicle manufacturers' warranties.

HISTORY: Laws, 1995, ch. 302, § 1, eff from and after passage (approved February 28, 1995).

§ 83-65-103. Definitions.

For the purposes of this chapter:

(a) "Commissioner" means the Commissioner of Insurance.

(b) "Service contract holder" means a person who purchases or otherwise obtains a vehicle service contract.

(c) "Vehicle service contract" means a contract or agreement that undertakes to perform or provide repair or replacement service, or provide payment for that service, for the operational or structural failure of a motor vehicle due to a defect in materials, workmanship or normal wear and tear, with or without additional provision for incidental payment or indemnity under limited circumstances, including, but not limited to, towing, rental and emergency road service. "Vehicle service contract" also means a contract or agreement that undertakes to perform or provide one or more of the following services:

(i) The repair or replacement of tires and/or wheels on a motor vehicle damaged as a result of coming into contact with road hazards;

(ii) The removal of dents, dings or creases on a motor vehicle that can be repaired using the process of paintless dent removal without affecting the existing paint finish and without replacing vehicle body panels, sanding, bonding or painting;

(iii) The repair of chips or cracks in or the replacement of motor vehicle windshields as a result of damage caused by road hazards;

(iv) The replacement of a motor vehicle key or key-fob in the event that the key or key-fob becomes inoperable or is lost or stolen;

(v) Other services which may be approved by the Commissioner, if not inconsistent with other provisions of this chapter.

(d) "Provider" means a person who issues, makes or provides a vehicle service contract.

(e) "Reimbursement insurance policy" means a policy of insurance providing reimbursement coverage for all services which the provider is legally obligated to provide under the terms of vehicle service contracts issued or sold by the provider.

(f) "Services" means the repair, replacement or maintenance of property or indemnification for repair, replacement or maintenance for the operational or structural failure of a motor vehicle due to a defect in materials, workmanship or normal wear and tear.

(g) "Road hazard" means a hazard that is encountered while driving a motor vehicle and which may include, but not be limited to, potholes, rocks, wood debris, metal parts, glass, plastic, curbs or composite scraps.

HISTORY: Laws, 1995, ch. 302, § 2, eff from and after passage (approved February 28, 1995); Laws, 2019, ch. 358, § 1, eff from and after July 1, 2019.

§ 83-65-105. Issuance, sale, or offer for sale of service contract; authorized providers.

A vehicle service contract shall not be issued, sold, or offered for sale in this state unless the provider of the vehicle service contract is a named insured under a reimbursement insurance policy issued by an insurer authorized to do business in this state.

HISTORY: Laws, 1995, ch. 302, § 3, eff from and after passage (approved February 28, 1995).

Cross References — Vehicle service contracts not subject to the requirements of §§ 83-65-105, 83-65-107, 83-65-109 and 83-65-111(a) and (b) under certain circumstances, see § 83-65-125.

§ 83-65-107. Issuance, sale, or offer for sale of service contract; document filing requirements; rates.

A vehicle service contract shall not be issued, sold, or offered for sale in this state unless a true and correct copy of the vehicle service contract and the provider's reimbursement insurance policy and the rates to be charged for the reimbursement insurance policy have been filed by the insurer issuing the reimbursement insurance policy with the commissioner. Rates shall not be excessive, inadequate or unfairly discriminatory.

HISTORY: Laws, 1995, ch. 302, § 4, eff from and after passage (approved February 28, 1995).

Cross References — Vehicle service contracts not subject to the requirements of §§ 83-65-105, 83-65-107, 83-65-109 and 83-65-111(a) and (b) under certain circumstances, see § 83-65-125.

§ 83-65-109. Issuance, sale, or offer for sale of reimbursement insurance policy.

A reimbursement insurance policy shall not be issued, sold, or offered for sale in this state unless the reimbursement insurance policy conspicuously states that the issuer of the policy shall provide on behalf of the provider all services which the provider is legally obligated to provide according to the provider's contractual obligations under the vehicle service contracts issued or sold by the provider.

HISTORY: Laws, 1995, ch. 302, § 5, eff from and after passage (approved February 28, 1995).

Cross References — Vehicle service contracts not subject to the requirements of §§ 83-65-105, 83-65-107, 83-65-109 and 83-65-111(a) and (b) under certain circumstances, see § 83-65-125.

§ 83-65-111. Issuance, sale, or offer for sale of service contract; form and terms of contract.

(1) A vehicle service contract shall not be issued, sold, or offered for sale in this state unless the contract conspicuously states that the obligations of the provider to the service contract holder to provide services are guaranteed under a reimbursement insurance policy, and unless the contract conspicuously states the name and address of the issuer of the reimbursement policy.

(2) Every vehicle service contract shall be written in clear, understandable language and shall be printed or typed in easy-to-read type, size and style, and shall not be issued, sold, or offered for sale in this state unless the contract:

(a) Conspicuously states that the services for which the provider is legally obligated to perform to the service contract holder are guaranteed under a reimbursement insurance policy;

(b) Conspicuously states the name and address of the issuer of the reimbursement insurance policy;

(c) Identifies the provider, the seller, and the service contract holder;

(d) Sets forth the total purchase price and the terms under which it is to be paid;

(e) Sets forth the procedure for making a claim, including a toll-free telephone number for claim service and a procedure for obtaining reimbursement for emergency repairs performed outside of normal business hours;

(f) Conspicuously states the existence of a deductible amount, if any;

(g) Specifies the merchandise or services, or both, to be provided and any limitations, exceptions or exclusions;

(h) Sets forth the conditions on which the use of non-original manufacturers parts, or substitute service, will be allowed;

(i) Conspicuously sets forth all of the obligations and duties of the service contract holder, such as the duty to protect against any further damage to the vehicle and the requirement for certain service and maintenance;

(j) Sets forth any terms, restrictions, or conditions governing transferability of the vehicle service contract.

HISTORY: Laws, 1995, ch. 302, § 6, eff from and after passage (approved February 28, 1995).

Cross References — Vehicle service contracts not subject to the requirements of §§ 83-65-105, 83-65-107, 83-65-109 and 83-65-111(a) and (b) under certain circumstances, see § 83-65-125.

§ 83-65-113. Use of particular words in names of providers, contracts or literature; false or misleading statements or omissions, etc., by providers; requirement of purchase of vehicle service contract as condition of loan or sale.

(1) Unless licensed as an insurance company, a provider shall not use in its name, contracts, or literature, any of the words "insurance," "casualty," "surety," "mutual," or any other words descriptive of the insurance, casualty, or surety business or deceptively similar to the name or description of any insurance or surety corporation, or any other vehicle service contract provider.

(2) A provider shall not, without the written consent of the purchaser, knowingly charge a purchaser for duplication of coverage or duties required by state or federal law, a warranty expressly issued by a manufacturer or seller of a product or any implied warranty enforceable against the lessor, seller, or manufacturer of a product.

(3) A provider shall not make, permit, or cause any false or misleading statements, either oral or written, in connection with the sale, offer to sell, or advertisement of a vehicle service contract.

(4) A provider shall not permit or cause the omission of any material statement in connection with the sale, offer to sell, or advertisement of a vehicle service contract, which under the circumstances should have been made in order to make the statements that were made not misleading.

(5) A provider shall not make, permit, or cause any false or misleading statements, either oral or written, about the benefits or services available under the vehicle service contract.

(6) A provider shall not make, permit, or cause any statement or practice which has the effect of creating or maintaining a fraud.

(7) A provider is prohibited from making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine or other publication, or in the form of a notice, circular, pamphlet, letter or poster, or over any radio or television station or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the vehicle service contract industry or with respect to any provider which is untrue, deceptive, or misleading.

(8) A person such as a bank, savings and loan association, insurance company, lending institution, manufacturer or seller of any product, shall not require the purchase of a vehicle service contract as a condition of a loan or a sale.

(9) A provider is prohibited from making, publishing, disseminating, or circulating, directly or indirectly, or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature which is false, or maliciously critical of or derogatory to the financial condition of any person, and which is calculated to injure such person.

(10) A provider is prohibited from entering into any agreement to commit, or by any concerted action committing, any act of boycott, coercion or intimidation resulting in or tending to result in unreasonable restraint of, or monopoly in, the service contract industry.

(11) A provider is prohibited from knowingly filing with any supervisory or other public official, or knowingly making, publishing, disseminating, circulating, or delivering to any person, or placing before the public, or knowingly causing directly or indirectly, to be made, published, disseminated, circulated, delivered to any person, or placed before the public, any false material statement of fact as to the financial condition of a person.

(12) A provider is prohibited from knowingly making any false entry of a material fact in any book, report, or statement of any person or knowingly omitting to make a true entry of any material fact pertaining to the business of such person in any book, report or statement of such person.

HISTORY: Laws, 1995, ch. 302, § 7, eff from and after passage (approved February 28, 1995).

§ 83-65-115. Recordkeeping requirements.

(1) All providers shall keep accurate accounts, books, and records concerning transactions regulated under this chapter.

(2) A provider's accounts, books, and records shall include:

(a) Copies of all service contracts;

(b) The name and address of each service contract holder to the extent that the name and address have been furnished by the service contract holder;

(c) The dates, amounts, and descriptions of all receipts, claims, and expenditures.

(3) A provider shall retain all required accounts, books, and records pertaining to each service contract holder for at least two (2) years after the specified period of coverage has expired. A provider discontinuing business in this state shall maintain its records until it furnishes the commissioner satisfactory proof that it has discharged all obligations to contract holders in this state.

(4) Providers shall make all accounts, books, and records concerning transactions regulated under this chapter available to the commissioner for the purpose of examination.

HISTORY: Laws, 1995, ch. 302, § 8, eff from and after passage (approved February 28, 1995).

§ 83-65-117. Cancellation of reimbursement insurance policy.

(1) The issuer of a reimbursement insurance policy shall not cancel such reimbursement insurance policy unless sixty (60) days written notice of cancellation has been given to the commissioner and to each insured provider, including automobile dealers and third-party administrators.

(2) The cancellation of a reimbursement insurance policy shall not reduce the issuer's responsibility for vehicle service contracts issued by providers prior to the date of cancellation.

HISTORY: Laws, 1995, ch. 302, § 9, eff from and after passage (approved February 28, 1995).

§ 83-65-119. Complaint against providers.

(1) The commissioner may receive and process each complaint made against any provider which alleges certain acts or practices which may constitute one or more violations of this chapter. Any member of the public, or any federal, state, or local official, may file a complaint with the commissioner. Complaints may be received from sources outside the State of Mississippi and processed in the same manner as those originating in Mississippi.

(2) All complaints shall be made in writing and shall fully identify the complainant by name and address. If required by the commissioner, complaints shall be made on forms prescribed and provided by the commissioner.

(3) Oral or telephone communications may not be considered or processed as complaints. However, any member of the staff of the commissioner may file a complaint based upon information and belief, in reliance upon oral, telephone, or written communications received by the commissioner.

HISTORY: Laws, 1995, ch. 302, § 10, eff from and after passage (approved February 28, 1995).

§ 83-65-121. Promulgation of regulations.

The commissioner may promulgate regulations necessary to effectuate this chapter.

HISTORY: Laws, 1995, ch. 302, § 11, eff from and after passage (approved February 28, 1995).

§ 83-65-123. Application of chapter.

If any provision of this chapter or the application thereof to any person or circumstance is held invalid by a court of competent jurisdiction, the remainder of the chapter or the applicability of such provision to other persons or circumstances shall not be affected.

HISTORY: Laws, 1995, ch. 302, § 12, eff from and after passage (approved February 28, 1995).

§ 83-65-125. Provider not required to be named insured under reimbursement insurance policy under certain circumstances.

(1) A provider shall not be required to be a named insured under a reimbursement insurance policy for purposes of issuing, selling or offering for sale a vehicle service contract in this state if the provider complies with the following requirements:

(a) Maintains, or has a parent company maintain, a net worth or stockholders' equity of at least One Hundred Million Dollars ($100,000,000.00);

(b) Upon request, files with the commissioner a true and correct copy of the vehicle service contract;

(c) Upon request, files with the commissioner a copy of the provider's or the provider's parent company's most recent Form 10-K or Form 20-F filed with the Securities and Exchange Commission within the preceding calendar year. If the provider or the provider's parent company does not file with the Securities and Exchange Commission, the provider, upon request, shall file with the commissioner a copy of the provider's or the provider's parent company's audited financial statements showing a net worth of the provider or its parent company of at least One Hundred Million Dollars ($100,000,000.00). If the provider's parent company's Form 10-K, Form 20-F or audited financial statements are filed to show that the provider meets the financial requirements of this section, the parent company shall agree to guarantee the obligations of the provider relating to service contracts sold by the provider in this state.

(2) If a provider complies with the requirements of subsection (1) the provider may issue, sell or offer for sale in this state vehicle service contracts and such contracts shall not be subject to the requirements of Sections 83-65-105, 83-65-107, 83-65-109 and subsections (2)(a) and (b) of Section 83-65-111.

HISTORY: Laws, 2011, ch. 401, § 1, eff from and after July 1, 2011.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected a typographical error in (1)(a). The word "company" was inserted between the words "parent" and "maintain" in following excerpt "(a) Maintains, or has a parent maintain. . ." so the phrase now reads "(a) Maintains, or has a parent company maintain. . ." The Joint Committee ratified the correction at its July 13, 2011, meeting.

CHAPTER 67.

UTILIZATION OF MODERN SYSTEMS FOR HOLDING AND TRANSFERRING SECURITIES WITHOUT PHYSICAL DELIVERY

Sec.
83-67-1. In general.
83-67-3. Definitions.
83-67-5. Deposit of securities with clearing corporation or Federal Reserve book-entry system; promulgation of rules and regulations.

§ 83-67-1. In general.

The purpose of this chapter is to authorize domestic insurance companies to utilize modern systems for holding and transferring securities without physical delivery of securities certificates, subject to appropriate regulations of the Commissioner of Insurance.

HISTORY: Laws, 2001, ch. 412, § 1, eff from and after July 1, 2001.

Cross References — Reserve liabilities and deposit requirements for life insurance companies, see § 83-7-21.

Capital requirements for various classes of domestic insurance companies, see § 83-19-31.

Capital and deposit requirements for admission of foreign insurance companies, see § 83-21-3

§ 83-67-3. Definitions.

As used in this chapter, the term:

(a) "Clearing corporation" means a corporation as defined in Section 75-8-102, except that with respect to securities issued by institutions organized or existing under the laws of any foreign country or securities used to meet the deposit requirements pursuant to the laws of a foreign country as a condition of doing business therein, clearing corporation may include a corporation which is organized or existing under the laws of any foreign country and is legally qualified under such laws to effect transactions in securities by computerized book-entry.

(b) "Direct participant" means a bank or trust company or other institution which maintains an account in its name in a clearing corporation and through which an insurance company participates in a clearing corporation.

(c) "Federal Reserve book-entry system" means the computerized systems sponsored by the United States Department of the Treasury and certain agencies and instrumentalities of the United States for holding and transferring securities of the United States government and such agencies and instrumentalities, respectively, in Federal Reserve Banks through banks which are members of the Federal Reserve System or which otherwise have access to such computerized systems.

(d) "Member bank" means a national bank, state bank or trust company which is a member of the Federal Reserve System and through which an insurance company participates in the Federal Reserve book-entry system.

(e) "Securities" means instruments as defined in Section 75-8-102 or as permitted by the insurance laws of the State of Mississippi.

HISTORY: Laws, 2001, ch. 412, § 2, eff from and after July 1, 2001.

§ 83-67-5. Deposit of securities with clearing corporation or Federal Reserve book-entry system; promulgation of rules and regulations.

(1) Notwithstanding any other provision of law, a domestic insurance company may deposit or arrange for the deposit of securities held in or purchased for its general account and its separate accounts in a clearing corporation or the Federal Reserve book-entry system. When securities are deposited with a clearing corporation, certificates representing securities of the same class of the same issuer may be merged and held in bulk in the name of the nominee of such clearing corporation with any other securities deposited with such clearing corporation by any person, regardless of the ownership of such securities, and certificates representing securities of small denominations may be merged into one or more certificates of larger denominations. The records of any member bank through which an insurance company holds securities in the Federal Reserve book-entry system, and the records of any custodian banks through which an insurance company holds securities in a clearing corporation shall at all times show that such securities are held for such insurance company and for which accounts thereof. Ownership of, and other interests in, such securities may be transferred by bookkeeping entry on the books of such clearing corporation or in the Federal Reserve book-entry system without, in either case, physical delivery of certificates representing such securities.

(2) The Commissioner of Insurance is authorized to promulgate rules and regulations governing the deposit by insurance companies of securities with clearing corporations and in the Federal Reserve book-entry system.

HISTORY: Laws, 2001, ch. 412, § 3, eff from and after July 1, 2001.

CHAPTER 69.

INTERSTATE INSURANCE PRODUCT REGULATION COMPACT

Sec.
83-69-1. Purposes; definitions; Interstate Insurance Product Regulation Commission creation, organization, meetings, and rulemaking functions; effective date of compact; withdrawal, default and termination; severability and construction; relationship to other laws.

§ 83-69-1. Purposes; definitions; Interstate Insurance Product Regulation Commission creation, organization, meetings, and rulemaking functions; effective date of compact; withdrawal, default and termination; severability and construction; relationship to other laws.

The Interstate Insurance Product Regulation Compact is enacted into law and entered into by this state with any and all states legally joining in accordance with its terms, in the form substantially as follows:

ARTICLE I.

PURPOSES.

The purposes of this Compact are, through means of joint and cooperative action among the Compacting States:

1. To promote and protect the interest of consumers of individual and group annuity, life insurance, disability income and long-term care insurance products;
2. To develop uniform standards for insurance products covered under the Compact;
3. To establish a central clearinghouse to receive and provide prompt review of insurance products covered under the Compact and, in certain cases, advertisements related thereto, submitted by insurers authorized to do business in one or more Compacting States;
4. To give appropriate regulatory approval to those product filings and advertisements satisfying the applicable uniform standard;
5. To improve coordination of regulatory resources and expertise between state insurance departments regarding the setting of Uniform Standards and review of insurance products covered under the Compact;
6. To create the Interstate Insurance Product Regulation Commission; and
7. To perform these and such other related functions as may be consistent with the state regulation of the business of insurance.

ARTICLE II.

DEFINITIONS.

For purposes of this Compact:

1. "Advertisement" means any material designed to create public interest in a product, or induce the public to purchase, increase, modify, reinstate, borrow on, surrender, replace or retain a policy, as more specifically defined in the Rules and Operating Procedures of the Commission.

2. "Bylaws" mean those bylaws established by the Commission for its governance, or for directing or controlling the Commission's actions or conduct.

3. "Compacting State" means any State which has enacted this Compact legislation and which has not withdrawn pursuant to Article XIV, Section 1, or been terminated pursuant to Article XIV, Section 2.

4. "Commission" means the "Interstate Insurance Product Regulation Commission" established by this Compact.

5. "Commissioner" means the chief insurance regulatory official of a State including, but not limited to, commissioner, superintendent, director or administrator.

6. "Domiciliary State" means the state in which an Insurer is incorporated or organized; or, in the case of an alien Insurer, its state of entry.

7. "Insurer" means any entity licensed by a State to issue contracts of insurance for any of the lines of insurance covered by this Compact.

8. "Member" means the person chosen by a Compacting State as its representative to the Commission, or his or her designee.

9. "Noncompacting State" means any State which is not at the time a Compacting State.

10. "Operating Procedures" mean procedures promulgated by the Commission implementing a Rule, Uniform Standard or a provision of this Compact.

11. "Product" means the form of a policy or contract, including any application, endorsement, or related form which is attached to and made a part of the policy or contract, and any evidence of coverage or certificate, for an individual or group annuity, life insurance, disability income or long-term care insurance product that an Insurer is authorized to issue.

12. "Rule" means a statement of general or particular applicability and future effect promulgated by the Commission, including a Uniform Standard developed pursuant to Article VII of this Compact, designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of the Commission, which shall have the force and effect of law in the Compacting States.

13. "State" means any state, district or territory of the United States of America.

14. "Third-Party Filer" means an entity that submits a product filing to the Commission on behalf of an Insurer.

15. "Uniform Standard" means a standard adopted by the Commission for

a product line, pursuant to Article VII of this Compact, and shall include all of the product requirements in aggregate; provided, that each Uniform Standard shall be construed, whether express or implied, to prohibit the use of any inconsistent, misleading or ambiguous provisions in a product and the form of the product made available to the public shall not be unfair, inequitable or against public policy as determined by the Commission.

ARTICLE III.

ESTABLISHMENT OF THE COMMISSION AND VENUE.

For purposes of this Compact:

1. The Compacting States hereby create and establish a joint public agency known as the "Interstate Insurance product Regulation Commission." Pursuant to Article IV, the Commission will have the power to develop Uniform Standards for product lines, receive and provide prompt review of products filed therewith, and give approval to those product filings satisfying applicable Uniform Standards; provided, it is not intended for the Commission to be the exclusive entity for receipt and review of insurance product filings. Nothing herein shall prohibit any Insurer from filing its product in any State wherein the Insurer is licensed to conduct the business of insurance; and any such filing shall be subject to the laws of the State where filed.

2. The Commission is a body corporate and politic, and an instrumentality of the Compacting States.

3. The Commission is solely responsible for its liabilities except as otherwise specifically provided in this Compact.

4. Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a Court of competent jurisdiction where the principal office of the Commission is located.

ARTICLE IV.

POWERS OF THE COMMISSION.

The Commission shall have the following powers:

1. To promulgate Rules, pursuant to Article VII of this Compact, which shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

2. To exercise its rulemaking authority and establish reasonable Uniform Standards for Products covered under the Compact, and Advertisement related thereto, which shall have the force and effect of law and shall be binding in the Compacting States, but only for those products filed with the Commission, provided, that a Compacting State shall have the right to opt out of such Uniform Standard pursuant to Article VII, to the extent and in the manner provided in this Compact, and, provided further, that any Uniform Standard established by the Commission for long-term care insur-

ance products may provide the same or greater protections for consumers as, but shall not provide less than, those protections set forth in the National Association of Insurance Commissioners' Long-Term Care Insurance Model Act and Long-Term Care Insurance Model Regulation, respectively, adopted as of 2001. The Commission shall consider whether any subsequent amendments to the NAIC Long-Term Care Insurance Model Act or Long-Term Care Insurance Model Regulation adopted by the NAIC require amending of the Uniform Standards established by the Commission for long-term care insurance products;

3. To receive and review in an expeditious manner products filed with the Commission, and rate filings for disability income and long-term care insurance products, and give approval of those products and rate filings that satisfy the applicable Uniform Standard, where such approval shall have the force and effect of law and be binding on the Compacting States to the extent and in the manner provided in the Compact;

4. To receive and review in an expeditious manner Advertisement relating to long-term care insurance products for which Uniform Standards have been adopted by the Commission, and give approval to all Advertisement that satisfies the applicable Uniform Standard. For any product covered under this Compact, other than long-term care insurance products, the Commission shall have the authority to require an Insurer to submit all or any part of its Advertisement with respect to that product for review or approval prior to use, if the Commission determines that the nature of the product is such that an Advertisement of the product could have the capacity or tendency to mislead the public. The actions of the Commission as provided in this section shall have the force and effect of law and shall be binding in the Compacting States to the extent and in the manner provided in the Compact;

5. To exercise its rulemaking authority and designate Products and Advertisement that may be subject to a self-certification process without the need for prior approval by the Commission.

6. To promulgate Operating Procedures, pursuant to Article VII of this Compact, which shall be binding in the Compacting States to the extent and in the manner provided in this Compact;

7. To bring and prosecute legal proceedings or actions in its name as the Commission; provided, that the standing of any state insurance department to sue or be sued under applicable law shall not be affected;

8. To issue subpoenas requiring the attendance and testimony of witnesses and the production of evidence;

9. To establish and maintain offices;

10. To purchase and maintain insurance and bonds;

11. To borrow, accept or contract for services of personnel, including, but not limited to, employees of a Compacting State;

12. To hire employees, professionals or specialists, and elect or appoint officers, and to fix their compensation, define their duties and give them appropriate authority to carry out the purposes of the Compact, and

determine their qualifications; and to establish the Commission's personnel policies and programs relating to, among other things, conflicts of interest, rates of compensation and qualifications of personnel;

13. To accept any and all appropriate donations and grants of money, equipment, supplies, materials and services, and to receive, utilize and dispose of the same; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

14. To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use, any property, real, personal or mixed; provided that at all times the Commission shall strive to avoid any appearance of impropriety;

15. To sell, convey, mortgage, pledge, lease, exchange, abandon or otherwise dispose of any property, real, personal or mixed;

16. To remit filing fees to Compacting States as may be set forth in the Bylaws, Rules or Operating Procedures;

17. To enforce compliance by Compacting States with Rules, Uniform Standards, Operating Procedures and Bylaws;

18. To provide for dispute resolution among Compacting States;

19. To advise Compacting States on issues relating to Insurers domiciled or doing business in Noncompacting jurisdictions, consistent with the purposes of this Compact;

20. To provide advice and training to those personnel in state insurance departments responsible for product review, and to be a resource for state insurance departments;

21. To establish a budget and make expenditures;

22. To borrow money;

23. To appoint committees, including advisory committees comprising members, state insurance regulators, state legislators or their representatives, insurance industry and consumer representatives, and such other interested persons as may be designated in the Bylaws;

24. To provide and receive information from, and to cooperate with law enforcement agencies;

25. To adopt and use a corporate seal; and

26. To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of the business of insurance.

ARTICLE V.

ORGANIZATION OF THE COMMISSION.

1. Membership, Voting and Bylaws.

a. Each Compacting State shall have and be limited to one (1) member. Each member shall be qualified to serve in that capacity pursuant to applicable law of the Compacting State. Any member may be removed or suspended from office as provided by the law of the State from which he or she shall be appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compacting State wherein the vacancy exists. Nothing herein shall be construed to affect the manner in which a Compacting State determines the election or appointment and qualification of its own Commissioner.

b. Each member shall be entitled to one (1) vote and shall have an opportunity to participate in the governance of the Commission in accordance with the Bylaws. Notwithstanding any provision herein to the contrary, no action of the Commission with respect to the promulgation of a Uniform Standard shall be effective unless two-thirds (⅔) of the members vote in favor thereof.

c. The Commission shall, by a majority of the members, prescribe Bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes, and exercise the powers, of the Compact, including, but not limited to:

i. Establishing the fiscal year of the Commission;

ii. Providing reasonable procedures for appointing and electing members, as well as holding meetings, of the Management Committee;

iii. Providing reasonable standards and procedures: (i) for the establishment and meetings of other committees, and (ii) governing any general or specific delegation of any authority or function of the Commission;

iv. Providing reasonable procedures for calling and conducting meetings of the Commission that consists of a majority of Commission members, ensuring reasonable advance notice of each such meeting and providing for the right of citizens to attend each such meeting with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and insurers' proprietary information, including trade secrets. The Commission may meet in camera only after a majority of the entire membership votes to close a meeting en toto or in part. As soon as practicable, the Commission must make public (i) a copy of the vote to close the meeting revealing the vote of each member with no proxy votes allowed, and (ii) votes taken during such meeting;

v. Establishing the titles, duties and authority and reasonable procedures for the election of the officers of the Commission;

vi. Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar laws of any Compacting State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

vii. Promulgating a code of ethics to address permissible and prohibited activities of Commission members and employees; and

viii. Providing a mechanism for winding up the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations.

d. The Commission shall publish its bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto, with the appropriate agency or officer in each of the Compacting States.

2. Management Committee, Officers and Personnel.

a. A Management Committee comprising no more than fourteen (14) members shall be established as follows:

i. One (1) member from each of the six (6) Compacting States with the largest premium volume for individual and group annuities, life, disability income and long-term care insurance products, determined from the records of the NAIC for the prior year;

ii. Four (4) members from those Compacting States with at least two percent (2%) of the market based on the premium volume described above, other than the six (6) Compacting States with the largest premium volume, selected on a rotating basis as provided in the Bylaws; and

iii. Four (4) members from those Compacting States with less than two percent (2%) of the market, based on the premium volume described above, with one (1) selected from each of the four (4) zone regions of the NAIC as provided in the Bylaws.

b. The Management Committee shall have such authority and duties as may be set forth in the Bylaws, including but not limited to:

i. Managing the affairs of the Commission in a manner consistent with the Bylaws and purposes of the Commission;

ii. Establishing and overseeing an organizational structure within, and appropriate procedures for, the Commission to provide for the creation of Uniform Standards and other Rules, receipt and review of product filings, administrative and technical support functions, review of decisions regarding the disapproval of a product filing, and the review of elections made by a Compacting State to opt out of a Uniform Standard; provided that a Uniform Standard shall not be submitted to the Compacting States for adoption unless approved by two-thirds (⅔) of the members of the Management Committee;

iii. Overseeing the offices of the Commission; and

iv. Planning, implementing, and coordinating communications and activities with other state, federal and local government organizations in order to advance the goals of the Commission.

c. The Commission shall elect annually officers from the Management Committee, with each having such authority and duties, as may be specified in the Bylaws.

d. The Management Committee may, subject to the approval of the Commission, appoint or retain an executive director for such period, upon such terms and conditions and for such compensation as the Commission may deem appropriate. The executive director shall serve as secretary to the Commission, but shall not be a member of the Commission. The executive director shall hire and supervise such other staff as may be authorized by the Commission.

3. Legislative and Advisory Committees.

a. A legislative committee comprising state legislators or their designees shall be established to monitor the operations of, and make recommendations to, the Commission, including the Management Committee; provided that the manner of selection and term of any legislative committee member shall be as set forth in the Bylaws. Prior to the adoption by the Commission of any Uniform Standard, revision to the Bylaws, annual budget or other significant matter as may be provided in the Bylaws, the Management Committee shall consult with and report to the legislative committee.

b. The Commission shall establish two (2) advisory committees, one (1) of which shall comprise consumer representatives independent of the insurance industry, and the other comprising insurance industry representatives.

c. The Commission may establish additional advisory committees as its Bylaws may provide for the carrying out of its functions.

4. Corporate Records of the Commission. The Commission shall maintain its corporate books and records in accordance with the Bylaws.

5. Qualified Immunity, Defense and Indemnification.

a. The members, officers, executive director, employees and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing in this paragraph shall be construed to protect any such person from suit and/or liability for any damage, loss, injury or liability caused by the intentional or willful and wanton misconduct of that person.

b. The Commission shall defend any member, officer, executive director, employee or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities; provided, that nothing herein shall be construed to prohibit that person from retaining his or her own counsel; and provided further, that the actual or alleged act, error or omission did not result from that person's intentional or willful and wanton misconduct.

c. The Commission shall indemnify and hold harmless any member, officer, executive director, employee or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error or omission that occurred within the scope of Commission employment, duties or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties or responsibilities, provided, that the actual or alleged act, error or omission did not result from the intentional or willful and wanton misconduct of that person.

ARTICLE VI.

MEETINGS AND ACTS OF THE COMMISSION AND VENUE.

1. The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

2. Each member of the Commission shall have the right and power to cast a vote to which that Compacting State is entitled and to participate in the business and affairs of the Commission. A member shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for members' participation in meetings by telephone or other means of communication.

3. The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

ARTICLE VII.

RULES AND OPERATING PROCEDURES: RULEMAKING FUNCTIONS OF THE COMMISSION AND OPTING OUT OF UNIFORM STANDARDS.

1. Rulemaking Authority. The Commission shall promulgate reasonable Rules, including Uniform Standards, and Operating Procedures in order to effectively and efficiently achieve the purposes of this Compact. Notwithstanding the foregoing, in the event the Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of this Compact, or the powers granted hereunder, then such an action by the Commission shall be invalid and have no force and effect.

2. Rulemaking Procedure. Rules and Operating Procedures shall be made pursuant to a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission. Before the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard. The Commission in adopting a Uniform Standard shall consider fully all submitted materials and issue a concise explanation of its decision.

3. Effective Date and Opt Out of a Uniform Standard. A Uniform Standard shall become effective ninety (90) days after its promulgation by the Commission or such later date as the Commission may determine; provided, however, that a Compacting State may opt out of a Uniform Standard as provided in this Article. "Opt out" shall be defined as any action by a Compacting State to decline to adopt or participate in a promulgated Uniform Standard. All other Rules and Operating Procedures, and amendments thereto, shall become effective as of the date specified in each Rule, Operating Procedure or amendment.

4. Opt Out Procedure. A Compacting State may opt out of a Uniform Standard, either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act. If a Compacting State elects to opt out of a Uniform Standard by regulation, it must (a) give written notice to the Commission no later than ten (10) business days after the Uniform Standard is promulgated, or at the time the State becomes a Compacting State and (b) find that the Uniform Standard does not provide reasonable protections to the citizens of the State, given the conditions in the State. The Commissioner shall make specific findings of fact and conclusions of law, based on a preponderance of the evidence, detailing the conditions in the State which warrant a departure from the Uniform Standard and determining that the Uniform Standard would not reasonably protect the citizens of the State. The Commissioner must consider and balance the following factors and find that the conditions in the State and needs of the citizens of the State outweigh: (i) the intent of the legislature to participate in, and the benefits of, an interstate agreement to establish national uniform consumer protections for the products subject to this Compact; and (ii) the presumption that a Uniform Standard adopted by the Commission provides reasonable protections to consumers of the relevant product.

Notwithstanding the foregoing, a Compacting State may, at the time of its enactment of this Compact, prospectively opt out of all Uniform Standards involving long-term care insurance products by expressly providing for such opt out in the enacted Compact, and such an opt out shall not be treated as a material variance in the offer or acceptance of any State to participate in this Compact. Such an opt out shall be effective at the time of enactment of this Compact by the Compacting State and shall apply to all existing Uniform Standards involving long-term care insurance products and those subsequently promulgated.

5. Effect of Opt Out. If a Compacting State elects to opt out of a Uniform Standard, the Uniform Standard shall remain applicable in the Compacting State electing to opt out until such time the opt out legislation is enacted into law or the regulation opting out becomes effective.

Once the opt out of a Uniform Standard by a Compacting State becomes effective as provided under the laws of that State, the Uniform Standard shall have no further force and effect in that State unless and until the legislation or regulation implementing the opt out is repealed or otherwise becomes ineffective under the laws of the State. If a Compacting State opts out of a Uniform Standard after the Uniform Standard has been made effective in that State, the opt out shall have the same prospective effect as provided under Article XIV for withdrawals.

6. Stay of Uniform Standard. If a Compacting State has formally initiated the process of opting out of a Uniform Standard by regulation, and while the regulatory opt out is pending, the Compacting State may petition the Commission, at least fifteen (15) days before the effective date of the Uniform Standard, to stay the effectiveness of the Uniform Standard in that State. The Commission may grant a stay if it determines the regulatory opt out is being

pursued in a reasonable manner and there is a likelihood of success. If a stay is granted or extended by the Commission, the stay or extension thereof may postpone the effective date by up to ninety (90) days, unless affirmatively extended by the Commission; provided, a stay may not be permitted to remain in effect for more than one (1) year unless the Compacting State can show extraordinary circumstances which warrant a continuance of the stay, including, but not limited to, the existence of a legal challenge which prevents the Compacting State from opting out. A stay may be terminated by the Commission upon notice that the rulemaking process has been terminated.

7. Not later than thirty (30) days after a Rule or Operating Procedure is promulgated, any person may file a petition for judicial review of the Rule or Operating Procedure; provided, that the filing of such a petition shall not stay or otherwise prevent the Rule or Operating Procedure from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Commission consistent with applicable law and shall not find the Rule or Operating Procedure to be unlawful if the Rule or Operating Procedure represents a reasonable exercise of the Commission's authority.

ARTICLE VIII.

COMMISSION RECORDS AND ENFORCEMENT.

1. The Commission shall promulgate Rules establishing conditions and procedures for public inspection and copying of its information and official records, except such information and records involving the privacy of individuals and insurers' trade secrets. The Commission may promulgate additional Rules under which it may make available to federal and state agencies, including law enforcement agencies, records and information otherwise exempt from disclosure, and may enter into agreements with such agencies to receive or exchange information or records subject to nondisclosure and confidentiality provisions.

2. Except as to privileged records, data and information, the laws of any Compacting State pertaining to confidentiality or nondisclosure shall not relieve any Compacting State Commissioner of the duty to disclose any relevant records, data or information to the Commission; provided, that disclosure to the Commission shall not be deemed to waive or otherwise affect any confidentiality requirement; and further provided, that, except as otherwise expressly provided in this Compact, the Commission shall not be subject to the Compacting State's laws pertaining to confidentiality and nondisclosure with respect to records, data and information in its possession. Confidential information of the Commission shall remain confidential after such information is provided to any Commissioner.

3. The Commission shall monitor Compacting States for compliance with duly adopted Bylaws, Rules, including Uniform Standards, and Operating Procedures. The Commission shall notify any noncomplying Compacting State in writing of its noncompliance with Commission Bylaws, Rules or Operating

Procedures. If a noncomplying Compacting State fails to remedy its noncompliance within the time specified in the notice of noncompliance, the Compacting State shall be deemed to be in default as set forth in Article XIV.

4. The Commissioner of any State in which an Insurer is authorized to do business, or is conducting the business of insurance, shall continue to exercise his or her authority to oversee the market regulation of the activities of the Insurer in accordance with the provisions of the State's law. The Commissioner's enforcement of compliance with the Compact is governed by the following provisions:

a. With respect to the Commissioner's market regulation of a Product or Advertisement that is approved or certified to the Commission, the content of the Product or Advertisement shall not constitute a violation of the provisions, standards or requirements of the Compact except upon a final order of the Commission, issued at the request of a Commissioner after prior notice to the Insurer and an opportunity for hearing before the Commission.

b. Before a Commissioner may bring an action for violation of any provision, standard or requirement of the Compact relating to the content of an Advertisement not approved or certified to the Commission, the Commission, or an authorized Commission officer or employee, must authorize the action. However, authorization pursuant to this paragraph does not require notice to the Insurer, opportunity for hearing or disclosure of requests for authorization or records of the Commission's action on such requests.

ARTICLE IX.

DISPUTE RESOLUTION.

The Commission shall attempt, upon the request of a member, to resolve any disputes or other issues that are subject to this Compact and which may arise between two (2) or more Compacting States, or between Compacting States and Noncompacting States, and the Commission shall promulgate an Operating Procedure providing for resolution of such disputes.

ARTICLE X.

PRODUCT FILING AND APPROVAL.

1. Insurers and Third-Party Filers seeking to have a product approved by the Commission shall file the product with, and pay applicable filing fees to, the Commission. Nothing in this Compact shall be construed to restrict or otherwise prevent an Insurer from filing its product with the insurance department in any State wherein the Insurer is licensed to conduct the business of insurance, and such filing shall be subject to the laws of the States where filed.

2. The Commission shall establish appropriate filing and review processes and procedures pursuant to Commission Rules and Operating Procedures. Notwithstanding any provision herein to the contrary, the Commission shall

promulgate Rules to establish conditions and procedures under which the Commission will provide public access to product filing information. In establishing such Rules, the Commission shall consider the interests of the public in having access to such information, as well as protection of personal medical and financial information and trade secrets, that may be contained in a product filing or supporting information.

3. Any product approved by the Commission may be sold or otherwise issued in those Compacting States for which the Insurer is legally authorized to do business.

ARTICLE XI.

REVIEW OF COMMISSION DECISIONS REGARDING FILINGS.

1. Not later than thirty (30) days after the Commission has given notice of a disapproved product or Advertisement filed with the Commission, the Insurer or Third-Party Filer whose filing was disapproved may appeal the determination to a review panel appointed by the Commission. The Commission shall promulgate Rules to establish procedures for appointing such review panels and provide for notice and hearing. An allegation that the Commission, in disapproving a Product or Advertisement filed with the Commission, acted arbitrarily, capriciously, or in a manner that is an abuse of discretion or otherwise not in accordance with the law, is subject to judicial review in accordance with Article III, Section 4.

2. The Commission shall have authority to monitor, review and reconsider Products and Advertisement subsequent to their filing or approval upon a finding that the product does not meet the relevant Uniform Standard. Where appropriate, the Commission may withdraw or modify its approval after proper notice and hearing, subject to the appeal process in Section 1 above.

ARTICLE XII.

FINANCE.

1. The Commission shall pay or provide for the payment of the reasonable expenses of its establishment and organization. To fund the cost of its initial operations, the Commission may accept contributions and other forms of funding from the National Association of Insurance Commissioners, Compacting States and other sources. Contributions and other forms of funding from other sources shall be of such a nature that the independence of the Commission concerning the performance of its duties shall not be compromised.

2. The Commission shall collect a filing fee from each Insurer and Third-Party Filer filing a product with the Commission to cover the cost of the operations and activities of the Commission and its staff in a total amount sufficient to cover the Commission's annual budget.

3. The Commission's budget for a fiscal year shall not be approved until it

has been subject to notice and comment as set forth in Article VII of this Compact.

4. The Commission shall be exempt from all taxation in and by the Compacting States.

5. The Commission shall not pledge the credit of any Compacting State, except by and with the appropriate legal authority of that Compacting State.

6. The Commission shall keep complete and accurate accounts of all its internal receipts, including grants and donations, and disbursements of all funds under its control. The internal financial accounts of the Commission shall be subject to the accounting procedures established under its Bylaws. The financial accounts and reports including the system of internal controls and procedures of the Commission shall be audited annually by an independent certified public accountant. Upon the determination of the Commission, but no less frequently than every three (3) years, the review of the independent auditor shall include a management and performance audit of the Commission. The Commission shall make an Annual Report to the Governor and legislature of the Compacting States, which shall include a report of the independent audit. The Commission's internal accounts shall not be confidential and such materials may be shared with the Commissioner of any Compacting State upon request provided, however, that any work papers related to any internal or independent audit and any information regarding the privacy of individuals and insurers' proprietary information, including trade secrets, shall remain confidential.

7. No Compacting State shall have any claim to or ownership of any property held by or vested in the Commission or to any Commission funds held pursuant to the provisions of this Compact.

ARTICLE XIII.

COMPACTING STATES, EFFECTIVE DATE AND AMENDMENT.

1. Any State is eligible to become a Compacting State.

2. The Compact shall become effective and binding upon legislative enactment of the Compact into law by two Compacting States; provided, the Commission shall become effective for purposes of adopting Uniform Standards for, reviewing, and giving approval or disapproval of, products filed with the Commission that satisfy applicable Uniform Standards only after twenty-six (26) States are Compacting States or, alternatively, by States representing greater than forty percent (40%) of the premium volume for life insurance, annuity, disability income and long-term care insurance products, based on records of the NAIC for the prior year. Thereafter, it shall become effective and binding as to any other Compacting State upon enactment of the Compact into law by that State.

3. Amendments to the Compact may be proposed by the Commission for enactment by the Compacting States. No amendment shall become effective

and binding upon the Commission and the Compacting States unless and until all Compacting States enact the amendment into law.

ARTICLE XIV.

WITHDRAWAL, DEFAULT AND TERMINATION.

1. Withdrawal.

a. Once effective, the Compact shall continue in force and remain binding upon each and every Compacting State; provided, that a Compacting State may withdraw from the Compact ("Withdrawing State") by enacting a statute specifically repealing the statute which enacted the Compact into law.

b. The effective date of withdrawal is the effective date of the repealing statute. However, the withdrawal shall not apply to any product filings approved or self-certified, or any Advertisement of such products, on the date the repealing statute becomes effective, except by mutual agreement of the Commission and the Withdrawing State unless the approval is rescinded by the Withdrawing State as provided in Paragraph e of this section.

c. The Commissioner of the Withdrawing State shall immediately notify the Management Committee in writing upon the introduction of legislation repealing this Compact in the Withdrawing State.

d. The Commission shall notify the other Compacting States of the introduction of such legislation within ten (10) days after its receipt of notice thereof.

e. The Withdrawing State is responsible for all obligations, duties and liabilities incurred through the effective date of withdrawal, including any obligations, the performance of which extend beyond the effective date of withdrawal, except to the extent those obligations may have been released or relinquished by mutual agreement of the Commission and the Withdrawing State. The Commission's approval of Products and Advertisement prior to the effective date of withdrawal shall continue to be effective and be given full force and effect in the Withdrawing State, unless formally rescinded by the Withdrawing State in the same manner as provided by the laws of the Withdrawing State for the prospective disapproval of products or advertisement previously approved under state law.

f. Reinstatement following withdrawal of any Compacting State shall occur upon the effective date of the Withdrawing State reenacting the Compact.

2. Default.

a. If the Commission determines that any Compacting State has at any time defaulted ("Defaulting State") in the performance of any of its obligations or responsibilities under this Compact, the Bylaws or duly promulgated Rules or Operating Procedures, then, after notice and hearing as set forth in the Bylaws, all rights, privileges and benefits conferred by this Compact on the Defaulting State shall be suspended from the effective date of default as fixed by the Commission. The grounds for default include, but are not limited to, failure of a Compacting State to perform its obligations or responsibilities, and any other grounds designated in Commission Rules. The Commission shall immediately notify the Defaulting State in writing of the Defaulting State's suspension pending a cure of the default. The Commission shall stipulate the conditions and the time period within which the Defaulting State must cure its default. If the Defaulting State fails to cure the default within the time period specified by the Commission, the Defaulting State shall be terminated from the Compact and all rights, privileges and benefits conferred by this Compact shall be terminated from the effective date of termination.

b. Product approvals by the Commission or product self-certifications, or any Advertisement in connection with such product, that are in force on the effective date of termination shall remain in force in the Defaulting State in the same manner as if the Defaulting State had withdrawn voluntarily pursuant to Section 1 of this article.

c. Reinstatement following termination of any Compacting State requires a reenactment of the Compact.

3. Dissolution of Compact.

a. The Compact dissolves effective upon the date of the withdrawal or default of the Compacting State which reduces membership in the Compact to one (1) Compacting State.

b. Upon the dissolution of this Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Commission shall be wound up and any surplus funds shall be distributed in accordance with the Bylaws.

ARTICLE XV.

SEVERABILITY AND CONSTRUCTION.

1. The provisions of this Compact shall be severable; and if any phrase, clause, sentence or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

2. The provisions of this Compact shall be liberally construed to effectuate its purposes.

ARTICLE XVI.

BINDING EFFECT OF COMPACT AND OTHER LAWS.

1. Other Laws

a. Nothing herein prevents the enforcement of any other law of a Compacting State, except as provided in Paragraph b of this section.

b. For any product approved or certified to the Commission, the Rules, Uniform Standards and any other requirements of the Commission shall constitute the exclusive provisions applicable to the content, approval and certification of such products. For Advertisement that is subject to the

Commission's authority, any Rule, Uniform Standard or other requirement of the Commission which governs the content of the Advertisement shall constitute the exclusive provision that a Commissioner may apply to the content of the Advertisement. Notwithstanding the foregoing, no action taken by the Commission shall abrogate or restrict: (i) the access of any person to state courts; (ii) remedies available under state law related to breach of contract, tort, or other laws not specifically directed to the content of the product; (iii) state law relating to the construction of insurance contracts; or (iv) the authority of the attorney general of the state including, but not limited to, maintaining any actions or proceedings, as authorized by law.

c. All insurance products filed with individual States shall be subject to the laws of those States.

2. Binding Effect of this Compact.

a. All lawful actions of the Commission, including all Rules and Operating Procedures promulgated by the Commission, are binding upon the Compacting States.

b. All agreements between the Commission and the Compacting States are binding in accordance with their terms.

c. Upon the request of a party to a conflict over the meaning or interpretation of Commission actions, and upon a majority vote of the Compacting States, the Commission may issue advisory opinions regarding the meaning or interpretation in dispute.

d. In the event any provision of this Compact exceeds the constitutional limits imposed on the legislature of any Compacting State, the obligations, duties, powers or jurisdiction sought to be conferred by that provision upon the Commission shall be ineffective as to that Compacting State, and those obligations, duties, powers or jurisdiction shall remain in the Compacting State and shall be exercised by the agency thereof to which those obligations, duties, powers or jurisdiction are delegated by law in effect at the time this Compact becomes effective.

HISTORY: Laws, 2009, ch. 357, § 1, eff from and after July 1, 2009.

Editor's Notes — In May 2006, both threshold goals for making this compact operational were met.

Cross References — Mississippi Administrative Procedures Law, see §§ 25-43-1.101 et seq.

Comparable Laws from other States — Alabama: Code of Ala. § 27-60-1 et seq.
Alaska: Alaska Stat. § 21.42.700.
Arizona: A.R.S. § 20-3251.
Arkansas: A.C.A. § 23-67-601 et seq.
Colorado: C.R.S. § 24-60-3001.
Connecticut: Conn. Gen. Stat. § 38a-37.
District of Columbia: D.C. Code § 31-1392.01 et seq.
Florida: Fla. Stat. § 626.9931 et seq.
Georgia: O.C.G.A. § 33-59A-1.
Hawaii: H.R.S. § 431:30-101 et seq.
Idaho: Idaho Code § 41-5702.

Illinois: 45 ILCS 162/1 et seq.
Indiana: Burn's Ind. Code Ann. § 27-8-31-1 et seq.
Iowa: Iowa Code § 505A.1.
Kansas: K.S.A. § 40-5301.
Kentucky: K.R.S. § 304.51-010.
Louisiana: La. R.S. § 22:2381.
Maine: 24-A M.R.S. § 2472.
Maryland: Md. INSURANCE Code Ann. § 29-101.
Massachusetts: ALM GL ch. 175K, § 1 et seq.
Michigan: MCLS § 3.1031.
Minnesota: Minn. Stat. § 60A.99.
Missouri: § 374.352 R.S.Mo.
Montana: 33-39-101, MCA.
Nebraska: R.R.S. Neb. § 44-7801.
Nevada: Nev. Rev. Stat. Ann. § 687C.010.
New Jersey: N.J. Stat. § 17B:37-1 et seq.
New Mexico: N.M. Stat. Ann. § 11-19-1.
North Carolina: N.C. Gen. Stat. § 58-91-1 et seq.
Ohio: Page's ORC Ann. § 3915.16.
Oklahoma: 36 Okl. St. § 7004.
Oregon: ORS § 732.820.
Pennsylvania: 40 P.S. § 4103.
Rhode Island: R.I. Gen. Laws, § 27-2.5-2.
South Carolina: S.C. Code Ann. § 38-95-10 et seq.
Tennessee: Tenn. Code Ann. § 56-58-102.
Texas: Tex. Ins. Code § 5001.002.
Utah: Utah Code Ann. § 31A-39-101.
Vermont: 8 V.S.A. § 8500 et seq.
Washington: Rev. Code Wash. (ARCW) § 48.130 et seq.
West Virginia: W.Va. Code § 33-47-1 et seq.
Wisconsin: Wis. Stat. § 601.58.
Wyoming: Wyo. Stat. § 26-15-201.

CHAPTER 71.

UNFAIR DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN HEALTH, LIFE, AND DISABILITY INCOME INSURANCE

Discrimination Against Subjects of Abuse in Health Insurance. 83-71-1
Discrimination Against Subjects of Abuse in Life Insurance. 83-71-51
Discrimination Against Subjects of Abuse in Disability Income Insurance. 83-71-101

DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN HEALTH INSURANCE

Sec.
83-71-1. Purpose.
83-71-3. Applicability of Sections 83-71-1 through 83-71-15 to health carriers and insurance professionals issuing or renewing health insurance policies or certificates of health insurance in Mississippi.
83-71-5. Definitions.
83-71-7. Unfair discriminatory acts; health insurance.
83-71-9. Health carrier or insurance professional taking adverse action on the basis of a medical condition health carrier or insurance professional knows is abuse-related required to provide explanation for action.
83-71-11. Health carriers to develop and adhere to written policies to protect the safety and privacy of subjects of abuse.
83-71-13. Investigation of written, signed complaints; adjudicatory proceeding; penalties for violations of Sections 83-71-1 through 83-71-15.
83-71-15. Applicability of Sections 83-71-1 through 83-71-15 to certain health benefit plans and certain applications for coverage under health benefit plans.

§ 83-71-1. Purpose.

The purpose of Sections 83-71-1 through 83-71-15 is to prohibit unfair discrimination by health carriers and insurance professionals on the basis of abuse status. Nothing in Sections 83-71-1 through 83-71-15 shall be construed to create or imply a private cause of action for a violation of Sections 83-71-1 through 83-71-15.

HISTORY: Laws, 2010, ch. 455, § 1, effective from and after July 1, 2010.

§ 83-71-3. Applicability of Sections 83-71-1 through 83-71-15 to health carriers and insurance professionals issuing or renewing health insurance policies or certificates of health insurance in Mississippi.

Sections 83-71-1 through 83-71-15 apply to all health carriers and insurance professionals involved in issuing or renewing in this state a policy or certificate of health insurance.

HISTORY: Laws, 2010, ch. 455, § 2, eff from and after July 1, 2010.

§ 83-71-5. Definitions.

As used in Sections 83-71-1 through 83-71-15, unless the context clearly indicates otherwise:

(a) "Abuse" means the occurrence of one or more of the following acts by a current or former family member, household member, intimate partner or caretaker:

(i) Attempting to cause or intentionally, knowingly or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault or involuntary sexual intercourse;

(ii) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person, including following the person or minor child without proper authority, under circumstances that place the person or minor child in reasonable fear of bodily injury or physical harm;

(iii) Subjecting another person to false imprisonment; or

(iv) Attempting to cause or intentionally, knowingly or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person.

(b) "Abuse-related medical condition" means a medical condition sustained by a subject of abuse which arises in whole or part out of abuse.

(c) "Abuse status" means the fact or perception that a person is, has been or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions.

(d) "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

(e) "Confidential abuse information" means information about acts of abuse or abuse status of a subject of abuse, a person's medical condition that the carrier knows or has reason to know is abuse-related, the address and telephone number (home and work) of a subject of abuse or the status of an applicant or insured as a family member, employer or associate of, or a person in a relationship with, a subject of abuse.

(f) "Health benefit plan" or "plan" means a policy, contract, certificate or agreement offered by a carrier or insurance professional to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. Health benefit plan includes accident only, credit health, dental, vision, Medicare supplement or long-term care insurance, coverage issued as a supplement to liability insurance, short-term and catastrophic health insurance policies and a policy that pays on a cost-incurred basis. Health benefit plan does not include workers' compensation or similar insurance.

(g) "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation or any other entity providing a plan of health insurance, health benefits or health services.

(h) "Insurance professional" means an agent, insurance producer, adjuster or third-party administrator as defined in the insurance laws of this state.

(i) "Insured" means a party named on a health benefit plan as the person with legal rights to the benefits provided by the health benefit plan. For group plans, "insured" includes a person who is a beneficiary covered by a group health benefit plan.

(j) "Subject of abuse" means a person: against whom an act of abuse has been directed; who has current or prior injuries, illnesses or disorders that resulted from abuse; or who seeks, may have sought or had reason to seek medical or psychological treatment for abuse, or protection, court-ordered protection or shelter from abuse.

HISTORY: Laws, 2010, ch. 455, § 3, eff from and after July 1, 2010.

§ 83-71-7. Unfair discriminatory acts; health insurance.

(1) It is unfairly discriminatory to:

(a) Deny, refuse to issue, renew or reissue, cancel or otherwise terminate a health benefit plan or restrict or exclude health benefit plan coverage or add a premium differential to any health benefit plan on the basis of the applicant's or insured's abuse status; or

(b) Exclude or limit coverage for losses or deny a claim incurred by an insured on the basis of the insured's abuse status;

(2) When the health carrier or insurance professional has information in its possession that clearly indicates that the insured or applicant is a subject of abuse, the disclosure or transfer of the confidential abuse information by a person employed by or contracting with a health carrier or insurance professional for any purpose or to any person is unfairly discriminatory, except disclosure or transfer:

(a) To the subject of abuse or an individual specifically designated in writing by the subject of abuse;

(b) To a health care provider for the direct provision of health care services;

(c) To a licensed physician identified and designated by the subject of abuse;

(d) When ordered by the commissioner or a court of competent jurisdiction or otherwise required by law;

(e) When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed only if the recipient has executed a written agreement to be bound by the prohibitions of Sections 83-71-1 through 83-71-15 in all respects and to be subject to the enforcement of Sections 83-71-1 through 83-71-15 by the courts of this state for the benefit of the applicant or the insured and only to the following persons:

(i) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

(ii) A party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the health carrier or insurance professional;

(iii) Medical or claims personnel contracting with the health carrier or insurance professional, only where necessary to process an application or perform the health carrier's or insurance professional's duties under the policy or to protect the safety or privacy of a subject of abuse (also includes parent or affiliate companies of the health carrier or insurance professional that have service agreements with the health carrier or insurance professional); or

(iv) With respect to address and telephone number, to entities with whom the health carrier or insurance professional transacts business when the business cannot be transacted without the address and telephone number;

(f) To an attorney who needs the information to represent the health carrier or insurance professional effectively, if the health carrier or insurance professional notifies the attorney of its obligations under Sections 83-71-1 through 83-71-15 and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the health carrier or insurance professional;

(g) To the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about abuse status; or

(h) To any other entities deemed appropriate by the commissioner.

(3) It is unfairly discriminatory to request information relating to acts of abuse or an applicant's or insured's abuse status or make use of that information, however obtained, except for the limited purposes of complying with legal obligations or verifying a person's claim to be a subject of abuse.

(4) It is unfairly discriminatory to terminate group coverage for a subject of abuse because coverage was originally issued in the name of the abuser and the abuser has divorced, separated from or lost custody of the subject of abuse or the abuser's coverage has terminated voluntarily or involuntarily. Nothing in this subsection prohibits the health carrier or insurance professional from requiring the subject of abuse to pay the full premium for coverage under the health plan or from requiring as a condition of coverage that the subject of abuse reside or work within its service area, if the requirements are applied to all insureds of the health carrier or insurance professional. The health carrier or insurance professional may terminate group coverage after the continuation coverage required by this subsection has been in force for eighteen (18) months, if it offers conversion to an equivalent individual plan. The continuation coverage required by this section shall be satisfied by coverage required under Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, provided to a subject of abuse and is not intended to be in addition to coverage provided under COBRA.

(5) Subsection (2) of this section does not preclude a subject of abuse from obtaining his or her insurance records.

(6) Subsection (3) of this section does not prohibit a health carrier or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under the policy, even if the medical information is related to a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related, to the extent otherwise permitted under Sections 83-71-1 through 83-71-15 and other applicable law.

HISTORY: Laws, 2010, ch. 455, § 4, eff from and after July 1, 2010.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation deleted "or" at the end of (2)(d). The Joint Committee ratified the correction at its August 10, 2022, meeting.

Federal Aspects — The Consolidated Omnibus Budget Reconciliation Act is codified as 29 USCS §§ 1161 et seq.

§ 83-71-9. Health carrier or insurance professional taking adverse action on the basis of a medical condition health carrier or insurance professional knows is abuse-related required to provide explanation for action.

A health carrier or insurance professional that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the health carrier or insurance professional knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action, and any applicable plan provision:

(a) Does not have the purpose or effect of treating abuse status as a medical condition or underwriting criterion;

(b) Is not based upon any actual or perceived correlation between a medical condition and abuse;

(c) Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition without regard to whether the condition or claim is abuse-related; and

(d) Except for claim actions, is based on a determination, made in conformance with sound actuarial principles and supported by reasonable statistical evidence, that there is a correlation between the medical condition and a material increase in insurance risk.

HISTORY: Laws, 2010, ch. 455, § 5, eff from and after July 1, 2010.

§ 83-71-11. Health carriers to develop and adhere to written policies to protect the safety and privacy of subjects of abuse.

Health carriers shall develop and adhere to written policies specifying procedures to be followed by employees and by insurance professionals they contract with for the purpose of protecting the safety and privacy of a subject of abuse and shall otherwise implement the provisions of Sections 83-71-1 through 83-71-15 when taking an application, investigating a claim, pursuing subrogation or taking any other action relating to a policy or claim involving a subject of abuse. Insurers shall distribute their written policies to employees and insurance professionals.

HISTORY: Laws, 2010, ch. 455, § 6, eff from and after July 1, 2010.

§ 83-71-13. Investigation of written, signed complaints; adjudicatory proceeding; penalties for violations of Sections 83-71-1 through 83-71-15.

The commissioner shall conduct a reasonable investigation based on a written and signed complaint received by the commissioner and shall issue a prompt determination as to whether a violation of Sections 83-71-1 through 83-71-15 may have occurred. If the commissioner finds from the investigation that a violation of Sections 83-71-1 through 83-71-15 may have occurred, the commissioner shall promptly begin an adjudicatory proceeding. The commissioner may address a violation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

HISTORY: Laws, 2010, ch. 455, § 7, eff from and after July 1, 2010.

§ 83-71-15. Applicability of Sections 83-71-1 through 83-71-15 to certain health benefit plans and certain applications for coverage under health benefit plans.

Sections 83-71-1 through 83-71-15 apply to every health benefit plan or plan that is issued, reissued, renewed or continued on or after July 1, 2010, and to every application that is submitted on or after July 1, 2010, for coverage under a health benefit plan or plan.

HISTORY: Laws, 2010, ch. 455, § 8, eff from and after July 1, 2010.

DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN LIFE INSURANCE

Sec.

83-71-51. Purpose.
83-71-53. Applicability of Sections 83-71-51 through 83-71-65 to life insurers and insurance professionals issuing or renewing life insurance policies or certificates of life insurance in Mississippi.
83-71-55. Definitions.
83-71-57. Unfair discriminatory acts; life insurance.
83-71-59. Insurer or insurance professional taking adverse action on the basis of a medical condition insurer or insurance professional knows is abuse-related required to provide explanation for action.
83-71-61. Insurers to develop and adhere to written policies to protect the safety and privacy of subjects of abuse.
83-71-63. Investigation of written, signed complaints; adjudicatory proceeding; penalties for violations of Sections 83-71-51 through 83-71-65.
83-71-65. Applicability of Sections 83-71-51 through 83-71-65 to certain policies or certificates of life insurance and certain applications for coverage under a policy or certificate of life insurance.

§ 83-71-51. Purpose.

The purpose of Sections 83-71-51 through 83-71-65 is to prohibit unfair discrimination by life insurers or insurance professionals on the basis of abuse status. Nothing in Sections 83-71-51 through 83-71-65 shall be construed to create or imply a private cause of action for a violation of Sections 83-71-51 through 83-71-65.

HISTORY: Laws, 2010, ch. 455, § 9, eff from and after July 1, 2010.

§ 83-71-53. Applicability of Sections 83-71-51 through 83-71-65 to life insurers and insurance professionals issuing or renewing life insurance policies or certificates of life insurance in Mississippi.

Sections 83-71-51 through 83-71-65 apply to all life insurers and insurance professionals involved in issuing or renewing in this state a policy or certificate of life insurance.

HISTORY: Laws, 2010, ch. 455, § 10, eff from and after July 1, 2010.

§ 83-71-55. Definitions.

As used in Sections 83-71-51 through 83-71-65, unless the context clearly indicates otherwise:

(a) "Abuse" means the occurrence of one or more of the following acts by a current or former family member, household member, intimate partner or caretaker:

(i) Attempting to cause or intentionally, knowingly or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault or involuntary sexual intercourse;

(ii) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person, including following the person without proper authority, under circumstances that place the person in reasonable fear of bodily injury or physical harm;

(iii) Subjecting another person to false imprisonment; or

(iv) Attempting to cause or intentionally, knowingly or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person.

(b) "Abuse-related medical condition" means a medical condition sustained by a subject of abuse which arises, in whole or in part, out of abuse.

(c) "Abuse status" means the fact or perception that a person is, has been or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions.

(d) "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

(e) "Confidential abuse information" means information about acts of abuse or abuse status of a subject of abuse, the address and telephone number (home and work) of a subject of abuse or the status of an applicant or insured as a family member, employer or associate of, or a person in a relationship with, a subject of abuse.

(f) "Insurance professional" means an agent, insurance producer, adjuster or third-party administrator as defined in the insurance laws of this state.

(g) "Insured" means the person whose life is covered under an insurance policy.

(h) "Insurer" means a person or other legal entity engaged in the business of life insurance in this state.

(i) "Policy" or "certificate" means a contract of insurance or annuity including endorsements, riders or binders issued, proposed for issuance or intended for issuance by an insurer or insurance professional.

(j) "Subject of abuse" means a person: against whom an act of abuse has been directed; who has current or prior injuries, illnesses or disorders that resulted from abuse; or who seeks, may have sought or had reason to seek medical or psychological treatment for abuse or protection, court-ordered protection or shelter from abuse.

HISTORY: Laws, 2010, ch. 455, § 11, eff from and after July 1, 2010.

§ 83-71-57. Unfair discriminatory acts; life insurance.

(1) It is unfairly discriminatory to:

(a) Deny, refuse to issue, refuse to renew or reissue, cancel or otherwise terminate, restrict or exclude insurance coverage on or add a premium differential to a policy for an applicant or insured on the basis of the applicant's or insured's abuse status; or

(b) Exclude, limit or deny benefits on a life insurance policy on the basis of an insured's abuse status except as otherwise permitted or required by the laws of this state relating to acts of abuse committed by a life insurance beneficiary.

(2) When the insurer or insurance professional has information in its possession that clearly indicates that the insured or applicant is a subject of abuse, the disclosure or transfer of confidential abuse information by a person employed by or contracting with an insurer or insurance professional for any purpose or to any person is unfairly discriminatory, except disclosure or transfer:

(a) To the subject of abuse or an individual specifically designated in writing by the subject of abuse;

(b) To a health care provider for the direct provision of health care services;

(c) To a licensed physician identified and designated by the subject of abuse;

(d) When ordered by the commissioner or a court of competent jurisdiction or otherwise required by law;

(e) When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed only if the recipient has executed a written agreement to be bound by the prohibitions of Sections 83-71-51 through 83-71-65 in all respects and to be subject to the enforcement of Sections 83-71-51 through 83-71-65 by the courts of this state for the benefit of the applicant or the insured, and only to the following persons:

(i) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

(ii) A party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer or insurance professional;

(iii) Medical or claims personnel contracting with the insurer or insurance professional, only where necessary to process an application or perform the insurer's or insurance professional's duties under the policy or to protect the safety or privacy of a subject of abuse (also includes parent or affiliate companies of the insurer or insurance professional that have service agreements with the insurer or insurance professional); or

(iv) With respect to address and telephone number, to entities with whom the insurer or insurance professional transacts business when the business cannot be transacted without the address and telephone number;

(f) To an attorney who needs the information to represent the insurer or insurance professional effectively, if the insurer or insurance professional notifies the attorney of its obligations under Sections 83-71-51 through 83-71-65 and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the insurer or insurance professional;

(g) To the policy owner or assignee, in the course of delivery of the policy, if the policy contains information about abuse status; or

(h) To any other entities deemed appropriate by the commissioner.

(3) It is unfairly discriminatory to request information about acts of abuse or abuse status or make use of that information, however obtained.

(4) Subsection (2) of this section does not preclude a subject of abuse from obtaining his or her insurance records.

(5) Subsection (1) of this section does not prohibit an insurer or insurance professional from declining to issue a life insurance policy if the applicant or prospective owner of the policy is or would be designated as a beneficiary of the policy, and if:

(a) The applicant or prospective owner of the policy lacks an insurable interest in the insured;

(b) The applicant or prospective owner of the policy is known, on the basis of medical, police or court records, to have committed an act of abuse against the proposed insured; or

(c) The insured or prospective insured is a subject of abuse, and that person, or a person who has assumed the care of that person if a minor or incapacitated, has objected to the issuance of the policy on the ground that the policy would be issued to or for the direct or indirect benefit of the abuser.

(6) Subsection (3) of this section does not prohibit an insurer or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under the policy, even if the medical information is related to a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related, to the extent otherwise permitted under Sections 83-71-51 through 83-71-65 and other applicable law.

(7) An insurer or insurance professional shall not be held civilly or criminally liable for the death of or injury to an insured resulting from any action taken in a good faith effort to comply with the requirements of Sections 83-71-51 through 83-71-65. However, this subsection does not prevent an action to investigate or enforce a violation of Sections 83-71-51 through 83-71-65 or to assert any other claims authorized by law.

HISTORY: Laws, 2010, ch. 455, § 12, eff from and after July 1, 2010.

§ 83-71-59. Insurer or insurance professional taking adverse action on the basis of a medical condition insurer or insurance professional knows is abuse-related required to provide explanation for action.

An insurer or insurance professional that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action, and any applicable policy provision:

(a) Does not have the purpose or effect of treating abuse status as a medical condition or underwriting criterion;

(b) Is not based upon any actual or perceived correlation between a medical condition and abuse;

(c) Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition without regard to whether the condition or claim is abuse-related; and

(d) Except for claims actions, is based on a determination, made in conformance with sound actuarial principles and otherwise supported by actual or reasonably anticipated experience, that there is a correlation between the medical condition and a material increase in insurance risk.

HISTORY: Laws, 2010, ch. 455, § 13, eff from and after July 1, 2010.

§ 83-71-61. Insurers to develop and adhere to written policies to protect the safety and privacy of subjects of abuse.

Insurers shall develop and adhere to written policies specifying procedures to be followed by employees and by insurance professionals with which they contract for the purpose of protecting the safety and privacy of a subject of abuse and shall otherwise implement the provisions of Sections 83-71-51 through 83 71-65 when taking an application, investigating a claim, pursuing subrogation or taking any other action relating to a policy or claim involving a subject of abuse. Insurers shall distribute their written policies to employees and insurance professionals.

HISTORY: Laws, 2010, ch. 455, § 14, eff from and after July 1, 2010.

§ 83-71-63. Investigation of written, signed complaints; adjudicatory proceeding; penalties for violations of Sections 83-71-51 through 83-71-65.

The commissioner shall conduct a reasonable investigation based on a written and signed complaint received by the commissioner and shall issue a prompt determination as to whether a violation of Sections 83-71-51 through 83-71-65 may have occurred. If the commissioner finds from the investigation that a violation of Sections 83-71-51 through 83-71-65 may have occurred, the commissioner shall promptly begin an adjudicatory proceeding. The commissioner may address a violation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

HISTORY: Laws, 2010, ch. 455, § 15, eff from and after July 1, 2010.

§ 83-71-65. Applicability of Sections 83-71-51 through 83-71-65 to certain policies or certificates of life insurance and certain applications for coverage under a policy or certificate of life insurance.

Sections 83-71-51 through 83 71-65 apply to every policy or certificate that is issued, reissued, renewed or continued on or after July 1, 2010, and to every application that is submitted on or after July 1, 2010, for coverage under a policy or certificate.

HISTORY: Laws, 2010, ch. 455, § 16, eff from and after July 1, 2010.

DISCRIMINATION AGAINST SUBJECTS OF ABUSE IN DISABILITY INCOME INSURANCE

Sec.

83-71-101. Purpose.
83-71-103. Applicability of Sections 83-71-101 through 83-71-115 to disability income insurers and insurance professionals issuing or renewing policies or certificates of disability income insurance in Mississippi.
83-71-105. Definitions.
83-71-107. Unfair discriminatory acts; disability income insurance.
83-71-109. Insurer or insurance professional taking adverse action on the basis of a medical condition insurer or insurance professional knows is abuse-related required to provide explanation for action.
83-71-111. Insurers to develop and adhere to written policies to protect the safety and privacy of subjects of abuse.
83-71-113. Investigation of written, signed complaints; adjudicatory proceeding; penalties for violations of Sections 83-71-101 through 83-71-115.
83-71-115. Applicability of Sections 83-71-101 through 83-71-115 to certain policies or certificates of disability income insurance and certain applications for coverage under a policy or certificate of disability income insurance.

§ 83-71-101. Purpose.

The purpose of Sections 83-71-101 through 83-71-115 is to prohibit unfair discrimination by disability income insurers and insurance professionals on the basis of abuse status. Nothing in Sections 83-71-101 through 83-71-115 shall be construed to create or imply a private cause of action for a violation of Sections 83-71-101 through 83-71-115.

HISTORY: Laws, 2010, ch. 455, § 17, eff from and after July 1, 2010.

§ 83-71-103. Applicability of Sections 83-71-101 through 83-71-115 to disability income insurers and insurance professionals issuing or renewing policies or certificates of disability income insurance in Mississippi.

Sections 83-71-101 through 83-71-115 apply to all disability income insurers and insurance professionals involved in issuing or renewing in this state a policy or certificate of disability income insurance.

HISTORY: Laws, 2010, ch. 455, § 18, eff from and after July 1, 2010.

§ 83-71-105. Definitions.

As used in Sections 83-71-101 through 83-71-115, unless the context clearly indicates otherwise:

(a) "Abuse" means the occurrence of one or more of the following acts by a current or former family member, household member, intimate partner or caretaker:

(i) Attempting to cause or intentionally, knowingly or recklessly causing another person bodily injury, physical harm, severe emotional distress, psychological trauma, rape, sexual assault or involuntary sexual intercourse;

(ii) Knowingly engaging in a course of conduct or repeatedly committing acts toward another person, including following the person without proper authority, under circumstances that place the person in reasonable fear of bodily injury or physical harm;

(iii) Subjecting another person to false imprisonment; or

(iv) Attempting to cause or intentionally, knowingly or recklessly causing damage to property so as to intimidate or attempt to control the behavior of another person.

(b) "Abuse-related medical condition" means a medical condition sustained by a subject of abuse which arises in whole or in part out of abuse.

(c) "Abuse status" means the fact or perception that a person is, has been or may be a subject of abuse, irrespective of whether the person has sustained abuse-related medical conditions.

(d) "Commissioner" means the Commissioner of Insurance of the State of Mississippi.

(e) "Confidential abuse information" means information about acts of abuse or abuse status of a subject of abuse, the address and telephone number (home and work) of a subject of abuse or the status of an applicant or insured as a family member, employer or associate of, or a person in a relationship with, a subject of abuse.

(f) "Insurance professional" means an agent, insurance producer, adjuster or third-party administrator as defined in the insurance laws of this state.

(g) "Insured" means a party named on a disability income policy or certificate as the person with legal rights to the benefits provided by the policy or certificate. For group insurance, "insured" includes a person who is a beneficiary covered by a group policy or certificate.

(h) "Insurer" means a person or other legal entity engaged in the business of disability income insurance in this state.

(i) "Policy" or "certificate" means a contract of insurance or indemnity, including endorsements, riders or binders issued, proposed for issuance or intended for issuance by an insurer or insurance professional.

(j) "Subject of abuse" means a person: against whom an act of abuse has been directed; who has current or prior injuries, illnesses or disorders that resulted from abuse; or who seeks, may have sought or had reason to seek medical or psychological treatment for abuse or protection, court-ordered protection or shelter from abuse.

HISTORY: Laws, 2010, ch. 455, § 19, eff from and after July 1, 2010.

§ 83-71-107. Unfair discriminatory acts; disability income insurance.

(1) It is unfairly discriminatory to:

(a) Deny, refuse to issue or renew, cancel or otherwise terminate, restrict or exclude insurance coverage on or add a premium differential to any disability income insurance policy on the basis of the applicant's or insured's abuse status; or

(b) Exclude or limit coverage for losses or deny a claim under a disability income insurance policy on the basis of an insured's abuse status.

(2) When the insurer or insurance professional has information in its possession that clearly indicates that the insured or applicant is a subject of abuse, the disclosure or transfer of confidential abuse information for any purpose or to any person is unfairly discriminatory, except disclosure or transfer:

(a) To the subject of abuse or an individual specifically designated in writing by the subject of abuse;

(b) To a health care provider for the direct provision of health care services;

(c) To a licensed physician identified and designated by the subject of abuse;

(d) When ordered by the commissioner or a court of competent jurisdiction or otherwise required by law;

(e) When necessary for a valid business purpose to transfer information that includes confidential abuse information that cannot reasonably be segregated without undue hardship. Confidential abuse information may be disclosed only if the recipient has executed a written agreement to be bound by the prohibitions of Sections 83-71-101 through 83-71-115 in all respects and to be subject to the enforcement of Sections 83-71-101 through 83-71-115 by the courts of this state for the benefit of the applicant or insured and only to the following persons:

(i) A reinsurer that seeks to indemnify or indemnifies all or any part of a policy covering a subject of abuse and that cannot underwrite or satisfy its obligations under the reinsurance agreement without that disclosure;

(ii) A party to a proposed or consummated sale, transfer, merger or consolidation of all or part of the business of the insurer or insurance professional;

(iii) Medical or claims personnel contracting with the insurer, only where necessary to process an application or perform the insurer's or insurance professional's duties under the policy or to protect the safety or privacy of a subject of abuse (also includes parent or affiliate companies of the insurer that have service agreements with the insurer or insurance professional); or

(iv) With respect to address and telephone number, to entities with whom the insurer or insurance professional transacts business when the business cannot be transacted without the address and telephone number;

(f) To an attorney who needs the information to represent the insurer or insurance professional effectively, provided the insurer or insurance professional notifies the attorney of its obligations under Sections 83-71-101 through 83-71-115 and requests that the attorney exercise due diligence to protect the confidential abuse information consistent with the attorney's obligation to represent the insurer or insurance professional;

(g) To the policyowner or assignee, in the course of delivery of the policy, if the policy contains information about the abuse status; or

(h) To any other entities deemed appropriate by the commissioner.

(3) It is unfairly discriminatory to request information about acts of abuse or abuse status or make use of that information, however obtained.

(4) Subsection (2) of this section does not preclude a subject of abuse from obtaining his or her insurance records.

(5) Subsection (3) of this section does not prohibit a disability income insurer or insurance professional from asking about a medical condition or from using medical information to underwrite or to carry out its duties under the policy, even if the medical information is related to a medical condition that the insurer knows or has reason to know is abuse-related, to the extent otherwise permitted under Sections 83-71-101 through 83-71-115 and other applicable law.

(6) A disability income insurer or insurance professional shall not be held civilly or criminally liable for the death of or injury to an insured resulting from an action taken in a good faith effort to comply with the requirements of Sections 83-71-101 through 83-71-115. However, this subsection does not prevent an action to investigate or enforce a violation of Sections 83-71-101 through 83-71-115 or to assert any other claims authorized by law.

HISTORY: Laws, 2010, ch. 455, § 20, eff from and after July 1, 2010.

§ 83-71-109. Insurer or insurance professional taking adverse action on the basis of a medical condition insurer or insurance professional knows is abuse-related required to provide explanation for action.

An insurer or insurance professional that takes an action that adversely affects an applicant or insured on the basis of a medical condition that the insurer or insurance professional knows or has reason to know is abuse-related shall explain the reason for its action to the applicant or insured in writing and shall be able to demonstrate that its action and any applicable policy provision:

(a) Does not have the purpose or effect of treating abuse status as a medical condition or underwriting criterion;

(b) Is not based upon any actual or perceived correlation between a medical condition and abuse;

(c) Is otherwise permissible by law and applies in the same manner and to the same extent to all applicants and insureds with a similar medical condition or disability without regard to whether the condition is abuse-related; and

(d) Except for claims actions, is based on a determination, made in conformance with sound actuarial principles and otherwise supported by actual or reasonably anticipated experience, that there is a correlation between the medical condition and a material increase in insurance risk.

HISTORY: Laws, 2010, ch. 455, § 21, eff from and after July 1, 2010.

§ 83-71-111. Insurers to develop and adhere to written policies to protect the safety and privacy of subjects of abuse.

Insurers shall develop and adhere to written policies specifying procedures to be followed by employees and by insurance professionals they contract with for the purpose of protecting the safety and privacy of a subject of abuse and shall otherwise implement the provisions of Sections 83-71-101 through 83-71-115 when taking an application, investigating a claim, pursuing subrogation or taking any other action relating to a policy or claim involving a subject of abuse. Insurers shall distribute their written policies to employees and insurance professionals.

HISTORY: Laws, 2010, ch. 455, § 22, eff from and after July 1, 2010.

§ 83-71-113. Investigation of written, signed complaints; adjudicatory proceeding; penalties for violations of Sections 83-71-101 through 83-71-115.

The commissioner shall conduct a reasonable investigation based on a written and signed complaint received by the commissioner and shall issue a prompt determination as to whether a violation of Sections 83-71-101 through 83-71-115 may have occurred. If the commissioner finds from the investigation that a violation of Sections 83-71-101 through 83-71-115 may have occurred, the commissioner shall promptly begin an adjudicatory proceeding. The commissioner may address a violation through means appropriate to the nature and extent of the violation, which may include suspension or revocation of certificates of authority or licenses, imposition of civil penalties, issuance of cease and desist orders, injunctive relief, a requirement for restitution, referral to prosecutorial authorities or any combination of these. The powers and duties set forth in this section are in addition to all other authority of the commissioner.

HISTORY: Laws, 2010, ch. 455, § 23, eff from and after July 1, 2010.

§ 83-71-115. Applicability of Sections 83-71-101 through 83-71-115 to certain policies or certificates of disability income insurance and certain applications for coverage under a policy or certificate of disability income insurance.

Sections 83-71-101 through 83-71-115 apply to every policy or certificate that is issued, reissued, renewed or continued on or after July 1, 2010, and to every application that is submitted on or after July 1, 2010, for coverage under a policy or certificate.

HISTORY: Laws, 2010, ch. 455, § 24, eff from and after July 1, 2010.

CHAPTER 73.

PORTABLE ELECTRONICS INSURANCE

Sec.
83-73-1. Definitions.
83-73-3. Licensure of vendors.
83-73-5. Requirements for sale of portable electronics insurance.
83-73-7. Authority of vendors of portable electronics.
83-73-9. Suspension or revocation of license; funding of agency expenses; deposit of monies into State General Fund.
83-73-11. Termination of portable electronics insurance.
83-73-13. Application for license and fees.
83-73-15. Rules and regulations.

§ 83-73-1. Definitions.

For purposes of this chapter, the following terms have the following meanings:

(a) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership or other legal entity.

(b) "Commissioner" means the Commissioner of Insurance for the State of Mississippi.

(c) "Customer" means a person who purchases portable electronics or services.

(d) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(e) "Location" means any physical location in the State of Mississippi or any website, call center site or similar location directed to residents of the State of Mississippi.

(f) "Portable electronics" means electronic devices that are portable in nature, their accessories and services related to the use of the device.

(g)(i) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics which may provide coverage for portable electronics against any one or more of the following causes of loss: loss, theft, inoperability due to mechanical failure, malfunction, damage or other similar causes of loss. The insurance shall not exceed Seven Thousand Five Hundred Dollars ($7,500.00).

(ii) "Portable electronics insurance" does not include:

1. A service contract governed by Section 75-24-91;

2. A policy of insurance covering a seller's or a manufacturer's obligations under a warranty; or

3. A homeowner's, renter's, private passenger automobile, commercial multiperil or similar policy.

(h) "Portable electronics transaction" means:

(i) The sale or lease of portable electronics by a vendor to a customer; or

(ii) The sale of a service related to the use of portable electronics by a vendor to a customer.

(i) "Portable electronics insurance producer" means a business entity required to be licensed under the laws of this state to sell, solicit or negotiate portable electronics insurance.

(j) "Subsidiary corporation" means any corporation in which a majority of the voting stock is owned, directly or indirectly, by another corporation.

(k) "Supervising entity" means a business entity that is a licensed insurer or insurance producer that is authorized by an insurer to supervise the administration of a portable electronics insurance program.

(*l*) "Vendor" means a business entity in the business of selling, soliciting or negotiating portable electronics transactions directly or indirectly.

HISTORY: Laws, 2012, ch. 449, § 1, eff from and after Jan. 1, 2013.

Cross References — State agencies and public officials providing information about the agency or office to the public on a website are required to regularly review and update that information, see § 25-1-117.

§ 83-73-3. Licensure of vendors.

(1) A vendor is required to hold a portable electronics insurance producer license to sell, solicit or negotiate coverage under a policy of portable electronics insurance.

(2) A portable electronics insurance producer license issued under this chapter shall authorize any employee, subsidiary corporation or authorized representative of the vendor to sell, solicit or negotiate coverage under a policy of portable electronics insurance to a customer at each location at which the vendor engages in portable electronics transactions.

(3) Notwithstanding any other provision of law, a license issued pursuant to this section shall authorize the licensee and its employees or authorized representatives to engage in those activities that are permitted in this section.

HISTORY: Laws, 2012, ch. 449, § 2, eff from and after Jan. 1, 2013.

§ 83-73-5. Requirements for sale of portable electronics insurance.

(1) At every location where portable electronics insurance is sold, solicited or negotiated to customers, brochures or other written materials shall be made available to a prospective customer which:

(a) Disclose that portable electronics insurance may provide a duplication of coverage already provided by a customer's homeowner's insurance policy, renter's insurance policy or other source of coverage;

(b) State that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics or services;

(c) Summarize the material terms of the insurance coverage, including:

(i) The identity of the insurer;

(ii) The identity of the supervising entity;

(iii) The amount of any applicable deductible and how it is to be paid;

(iv) Benefits of the coverage; and

(v) Key terms and conditions of coverage such as whether portable electronics may be repaired or replaced with similar make and model reconditioned or nonoriginal manufacturer parts or equipment;

(d) Summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and

(e) State that an enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time and the person paying the premium shall receive a refund of any applicable unearned premium.

(2) Portable electronics insurance may be offered on a month-to-month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers.

(3) Eligibility and underwriting standards for customers electing to enroll in coverage shall be established for each portable electronics insurance program.

HISTORY: Laws, 2012, ch. 449, § 3, eff from and after Jan. 1, 2013.

§ 83-73-7. Authority of vendors of portable electronics.

(1) The employees, subsidiary corporations and authorized representatives of vendors may sell, solicit or negotiate portable electronics insurance to customers and shall not be subject to licensure as an insurance producer under this chapter provided that:

(a) The employee, subsidiary corporation or authorized representative is only engaged in the sale, solicitation or negotiation of portable electronics insurance;

(b) The vendor obtains a portable electronics insurance producer license to authorize its employees, subsidiary corporations or authorized representatives to sell, solicit or negotiate portable electronics insurance pursuant to this chapter;

(c) The insurer issuing the portable electronics insurance either directly supervises or shall authorize a supervising entity to supervise the administration of the program including development of a training program for employees, subsidiary corporations and authorized representatives of the vendors. The training required by this paragraph (c) shall comply with the following:

(i) The training shall be delivered to employees, subsidiary corporations and authorized representatives of vendors who are directly engaged in the activity of selling, soliciting or negotiating portable electronics insurance;

(ii) The training may be provided in electronic form. However, if conducted in an electronic form, the supervising entity shall implement a supplemental education program regarding the portable electronics insurance product that is conducted and overseen by licensed employees of the supervising entity; and

(iii) Each employee, subsidiary corporation and authorized representative shall receive basic instruction about the portable electronics insurance offered to customers and the disclosures required under Section 83-73-5;

(d) No employee, subsidiary corporation or authorized representative of a vendor of portable electronics shall advertise, represent or otherwise hold himself out as a licensed portable electronics insurance producer.

(2) Notwithstanding any other provision of law, employees, subsidiary corporation or authorized representatives of a vendor of portable electronics shall not be compensated based primarily on the number of customers enrolled for portable electronics insurance coverage, but may receive compensation for activities under the portable electronics insurance producer license which is incidental to their overall compensation.

(3) The charges for portable electronics insurance coverage may be billed and collected by the vendor of portable electronics. Any charge to the enrolled customer for coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the enrolled customer's bill. If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services. Vendors billing and collecting such charges shall not be required to maintain the funds in a segregated or trust account, provided that the vendor is authorized by the insurer to hold the funds in an alternative manner and remits such amounts to the supervising entity within sixty (60) days of receipt. All funds received by a vendor from an enrolled customer for the sale of portable electronics insurance shall be considered funds held in trust by the vendor in a fiduciary capacity for the benefit of the insurer. Vendors may receive compensation for billing and collection services.

HISTORY: Laws, 2012, ch. 449, § 4, eff from and after Jan. 1, 2013.

§ 83-73-9. Suspension or revocation of license; funding of agency expenses; deposit of monies into State General Fund.

(1) If a vendor of portable electronics or its employee, subsidiary corporation or authorized representative violates any provision of this section, the commissioner may do any of the following:

(a) After notice and hearing, impose fines not to exceed One Thousand Dollars ($1,000.00) per violation or Thirty Thousand Dollars ($30,000.00) in the aggregate for such violations and such penalty shall be deposited into the special fund of the State Treasury designated as the "Insurance Department Fund."

(b) After notice and hearing, impose other penalties that the commissioner deems necessary and reasonable to carry out the purpose of this chapter, including, but not limited to:

(i) Suspending the privilege of transacting portable electronics insurance pursuant to this section at specific business locations where violations have occurred;

(ii) Suspending or revoking the ability of individual employees, subsidiary corporations or authorized representatives to act under the license; and

(iii) Placing on probation, suspending or revoking the license of the portable electronics insurance producer.

(2) From and after July 1, 2016, the expenses of this agency shall be defrayed by appropriation from the State General Fund and all user charges and fees authorized under this section shall be deposited into the State General Fund as authorized by law.

(3) From and after July 1, 2016, no state agency shall charge another state agency a fee, assessment, rent or other charge for services or resources received by authority of this section.

HISTORY: Laws, 2012, ch. 449, § 5; Laws, 2016, ch. 459, § 35, eff from and after July 1, 2016.

Editor's Notes — Laws of 2016, ch. 459, § 1, codified as § 27-104-201, provides:

"SECTION 1. This act shall be known and may be cited as the 'Mississippi Budget Transparency and Simplification Act of 2016.' "

Cross References — Prohibition against one state agency charging another state agency fees, etc., for services or resources received, see § 27-104-203.

Defrayal of expenses of certain state agencies by appropriation of Legislature from General Fund, see § 27-104-205.

§ 83-73-11. Termination of portable electronics insurance.

(1) Notwithstanding any other provision of law, the terms for the termination or modification of a policy of portable electronics insurance shall be as follows:

(a) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least thirty (30) days' notice.

(b) If the insurer changes the terms and conditions, then the insurer shall provide the vendor policyholder with a revised policy or endorsement and each enrolled customer with a revised certificate, endorsement, updated brochure, or other evidence indicating a change in the terms and conditions has occurred and a summary of material changes.

(c) Notwithstanding paragraph (a) of this subsection, an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon fifteen (15) days' notice for nonpayment of premium, discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim thereunder.

(d) Notwithstanding paragraph (a) of this subsection, an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(i) If the enrolled customer ceases to have an active service with the vendor of portable electronics; or

(ii) If an enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within thirty (30) calendar days after exhaustion of the limit. However, if notice is not timely sent, enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer.

(e) Where a portable electronics insurance policy is terminated by a policyholder, the policyholder shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the policy and the effective date of termination. The written notice shall be mailed or delivered to the enrolled customer at least thirty (30) days prior to the termination.

(2) Whenever notice or correspondence with respect to a policy of portable electronics insurance is required pursuant to the policy or is otherwise required by law, it shall be in writing and sent within the notice period, if any, specified within the statute or regulation requiring the notice or correspondence. Notwithstanding any other provision of law, notices and correspondence may be sent either by mail or by electronic means as set forth in this subsection. If the notice or correspondence is mailed, it shall be sent to the vendor of portable electronics at the vendor's mailing address specified for such purpose and to its affected enrolled customers' last-known mailing addresses on file with the insurer. The insurer or vendor of portable electronics, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service. If the notice or correspondence is sent by electronic means, it shall be sent to the vendor of portable electronics at the vendor's electronic mail address specified for such purpose and to its affected enrolled customers' last-known electronic mail address as provided by each enrolled customer to the insurer or vendor of portable electronics, as the case may be. For purposes of this subsection, an enrolled customer's provision of an electronic mail address to the insurer or vendor of portable electronics, as the case may be, shall be deemed consent to receive notices and correspondence by electronic means. The insurer or vendor of portable electronics, as the case may be, shall maintain proof that the notice or correspondence was sent.

(3) Notice or correspondence required by this section or otherwise required by law may be sent on behalf of an insurer or vendor, as the case may be, by the supervising entity authorized by the insurer.

HISTORY: Laws, 2012, ch. 449, § 6, eff from and after Jan. 1, 2013.

§ 83-73-13. Application for license and fees.

(1) A sworn application for a license under this chapter shall be filed with the Mississippi Insurance Department on forms prescribed and furnished by the department.

(2) Portable electronics insurance producer licenses issued pursuant to this chapter shall continue from the date of issuance until December 31 in the second year following issuance or renewal of the license, with a minimum term of thirteen (13) months.

(3) Each vendor of portable electronics licensed under this chapter shall pay to the Mississippi Insurance Department a fee of Five Thousand Dollars ($5,000.00).

HISTORY: Laws, 2012, ch. 449, § 7, eff from and after Jan. 1, 2013.

§ 83-73-15. Rules and regulations.

The commissioner may promulgate reasonable rules and regulations to implement this chapter.

HISTORY: Laws, 2012, ch. 449, § 8, eff from and after Jan. 1, 2013.

CHAPTER 75.

HOMEOWNERS INSURANCE DISCOUNT FOR HURRICANE OR WINDSTORM DAMAGE MITIGATION

Sec.	
83-75-1.	Discount, rate reduction or adjustment for new home hurricane mitigation construction in certain localities.
83-75-3.	Discount, rate reduction or adjustment for existing home hurricane mitigation retrofit in certain localities.
83-75-5.	Definitions.
83-75-7.	Rules and regulations.

§ 83-75-1. Discount, rate reduction or adjustment for new home hurricane mitigation construction in certain localities.

(1) Not later than July 1, 2013, insurance companies shall provide a premium discount or insurance rate reduction in an amount and manner as established in subsection (6) of this section and according to Section 83-75-5. In addition, insurance companies may also offer additional adjustments in deductible, other credit rate differentials, or a combination thereof, collectively referred to as adjustments. These adjustments shall be available under the terms specified in this section to any owner who builds or locates a new insurable property in Harrison, Hancock, Jackson, Stone and Pearl River Counties, to resist loss due to hurricane or other catastrophic windstorm events.

(2) Not later than July 1, 2019, insurance companies shall provide a premium discount or insurance rate reduction for new residential insurable property in an amount and manner as established in subsection (6) of this section and according to Section 83-75-5. In addition, insurance companies may also offer additional adjustments in deductible, other credit rate differentials, or a combination thereof, collectively referred to as adjustments. These adjustments shall be available under the terms specified in this section to any owner who builds or locates a new residential insurable property to resist loss due to tornado or other catastrophic windstorm events in any county located in the State of Mississippi.

(3) Not later than July 1, 2021, insurance companies shall provide a premium discount or insurance rate reduction for new commercial insurable property in an amount and manner as established in subsection (6) of this section and according to Section 83-75-5. In addition, insurance companies may also offer additional adjustments in deductible, other credit rate differentials, or a combination thereof, collectively referred to as adjustments. These adjustments shall be available under the terms specified in this section to any owner who builds or locates a new commercial insurable property to resist loss due to hurricane, tornado or other catastrophic windstorm events in any county located in the State of Mississippi.

(4) To obtain the adjustment provided in this section, an insurable property located in this state shall be certified as constructed in accordance with (a) the 2006 or newer version of the International Residential Code, as amended, including the entire coastal construction supplement as recommended by the Mississippi Windstorm Mitigation Coordination Council; or (b) the 2012 or newer version of the International Building Code, as amended; or (c) the Fortified for Safer Living or similar programs adopted by the Insurance Institute for Business and Home Safety; or (d) any other mitigation program recommended by the Mississippi Windstorm Mitigation Coordination Council and approved by the Commissioner of Insurance. An insurable property shall be certified as conforming to the applicable building codes only after an evaluation of the insurable property has been satisfactorily completed by a building official or a certified and licensed building evaluator. An insurable property shall be certified as conforming to Fortified for Safer Living criteria only after evaluation and certification by an Insurance Institute for Business and Home Safety certified evaluator.

(5) An owner of insurable property claiming an adjustment under this section shall maintain sufficient certification records and construction records including, but not limited to, a Certificate of Occupancy denoting compliance with the applicable building code in subsection (4)(a) of this section or valid certification from the Insurance Institute for Business and Home Safety for compliance with the program described in subsection (4)(b) of this section.

(6) Insurers required to submit rates and rating plans to the commissioner shall submit an actuarially justified rating plan for any person who builds an insurable property to comply with the sets of requirements of subsection (4) of this section. An insurer is not required to provide the same amount of adjustment for a building code insurable property as the insurer would to a Fortified for Safer Living insurable property. An adjustment shall only apply to policies that provide wind coverage and may apply to that portion of the premium for wind coverage or to the total premium if the insurer does not separate out its premium for wind coverage in its rate filing. The adjustment shall apply exclusively to the premium designated for the improved insurable property. In addition to the requirements of this section, an insurer may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

HISTORY: Laws, 2012, ch. 443, § 1, eff from and after July 1, 2012; Laws, 2018, ch. 311, § 1, eff from and after July 1, 2018; Laws, 2020, ch. 342, § 1, eff from and after July 1, 2020.

§ 83-75-3. Discount, rate reduction or adjustment for existing home hurricane mitigation retrofit in certain localities.

(1) Not later than July 1, 2013, insurance companies shall provide a premium discount or insurance rate reduction in an amount and manner as established in subsection (5) of this section and according to Section 83-75-5. In

addition, insurance companies may also offer additional adjustments in deductible, other credit rate differentials, or a combination thereof, collectively referred to as adjustments. These adjustments shall be available under the terms specified in this section to any owner who retrofits his or her insurable property in Harrison, Hancock, Jackson, Stone and Pearl River Counties to resist loss due to hurricane or other catastrophic windstorm events.

(2) Not later than July 1, 2021, insurance companies shall provide a premium discount or insurance rate reduction in an amount and manner as established in subsection (5) of this section and according to Section 83-75-5. In addition, insurance companies may also offer additional adjustments in deductible, other credit rate differentials, or a combination thereof, collectively referred to as adjustments. These adjustments shall be available under the terms specified in this section to any owner who retrofits existing commercial insurable property to resist loss due to tornado or other catastrophic windstorm events in any county located in the State of Mississippi.

(3) To obtain the adjustment provided in this section, an insurable property shall be retrofitted to one (1) of the tiered mitigation levels as defined by the Insurance Institute for Business and Home Safety, or other mitigation program, or other construction technique, or standardized code that is recommended by the Mississippi Windstorm Mitigation Coordination Council and approved by the Commissioner of Insurance. Zone three HUD code manufactured homes installed to specifications and regulations promulgated by the Commissioner of Insurance shall be considered. An insurable property shall be certified as conforming to Fortified for Safer Homes requirements only after evaluation and certification by an Insurance Institute for Business and Home Safety certified evaluator. Certification of conformity of an insurable property with the other mitigation program, other construction technique, or other standardized code shall be made only by a building official or other certified or licensed building evaluator.

(4) An owner of insurable property claiming an adjustment under this section shall maintain sufficient certification records and construction records including, but not limited to, a certification of compliance with an approved mitigation program as promulgated by the Mississippi Windstorm Mitigation Coordination Council and approved by the Commissioner of Insurance or valid certification from the Insurance Institute for Business and Home Safety for compliance with a program described in subsection (3) of this section.

(5) Insurers required to submit rates and rating plans to the commissioner shall submit actuarially justified rating plans for any person who retrofits an insurable property to comply with the sets of alternatives provided in subsection (3) of this section. The adjustment shall only apply to policies that provide wind coverage and may apply to that portion of the premium for wind coverage or to the total premium if the insurer does not separate out its premium for wind coverage in its rate filing. The adjustment shall apply exclusively to the premium designated for the improved insurable property. In addition to the requirements of this section, an insurer may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

HISTORY: Laws, 2012, ch. 443, § 2, eff from and after July 1, 2012; Laws, 2020, ch. 342, § 2, eff from and after July 1, 2020.

§ 83-75-5. Definitions.

For the purposes of this chapter, the term "insurable property" includes single-family residential and commercial property. "Insurable property" also includes modular homes satisfying the codes, standards, or techniques as provided in Section 83-75-1 or 83-75-3. Manufactured homes or mobile homes are excluded from "insurable property," except as expressly provided in Section 83-75-3(3).

HISTORY: Laws, 2012, ch. 443, § 3, eff from and after July 1, 2012; Laws, 2020, ch. 342, § 3, eff from and after July 1, 2021.

§ 83-75-7. Rules and regulations.

The Commissioner of Insurance shall promulgate such rules and regulations as are necessary to implement and administer this chapter.

HISTORY: Laws, 2012, ch. 443, § 4, eff from and after July 1, 2012.

CHAPTER 77.

HEALTH CARE SHARING MINISTRIES

Sec.
83-77-1. Health care sharing ministry defined; health care sharing ministry not to be considered to be engaged in business of insurance.

§ 83-77-1. Health care sharing ministry defined; health care sharing ministry not to be considered to be engaged in business of insurance.

(1) This chapter shall be known as the "Health Care Sharing Ministries Freedom to Share Act."

(2) A health care sharing ministry shall not be considered to be engaging in the business of insurance for purposes of this Title 83, Mississippi Code of 1972.

(3) "Health care sharing ministry" means a faith-based, nonprofit organization that is tax exempt under the Internal Revenue Code which:

(a) Limits its participants to those who are of a similar faith;

(b) Acts as a facilitator among participants who have financial or medical needs and matches those participants with other participants with the present ability to assist those with financial or medical needs in accordance with criteria established by the health care sharing ministry;

(c) Provides for the financial or medical needs of a participant through contributions from one (1) participant to another;

(d) Provides amounts that participants may contribute with no assumption of risk or promise to pay among the participants and no assumption of risk or promise to pay by the health care sharing ministry to the participants;

(e) Provides a written monthly statement to all participants that lists the total dollar amount of qualified needs submitted to the health care sharing ministry, as well as the amount actually published or assigned to participants for their contribution; and

(f) Provides a written disclaimer on or accompanying all applications and guideline materials distributed by or on behalf of the organization that reads, in substance: "Notice: The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation is an insurance policy. Whether anyone chooses to assist you with your medical bills will be totally voluntary because no other participant will be compelled by law to contribute toward your medical bills. As such, participation in the organization or a subscription to any of its documents should never be considered to be insurance. Regardless of whether you receive any payment of medical expenses or whether this organization continues to operate, you are always personally responsible for the payment of your own medical bills."

HISTORY: Laws, 2014, ch. 377, § 1, eff from and after July 1, 2014.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation corrected two typographical errors in the Notice in (3)(f) by substituting "neither its guidelines nor plan of operation" for "neither its guideline nor plan or operation." The Joint Committee ratified the correction at its July 24, 2014, meeting.

CHAPTER 79.

PROPERTY INSURANCE CLARITY ACT

Sec.	
83-79-1.	Short title [Repealed effective July 1, 2022].
83-79-3.	Insurers authorized to transact homeowners insurance business in Mississippi required to provide certain policy and premium information to Department of Insurance; specific information to be provided [Repealed effective July 1, 2022].
83-79-5.	Insurers authorized to transact homeowners insurance business in Mississippi required to provide certain policy and premium information to Department of Insurance for calendar years 2005 through 2014 [Repealed effective July 1, 2022].
83-79-7.	Waiver, modification or extension for an additional time period of the reporting requirements; penalty for noncompliance with reporting requirements [Repealed effective July 1, 2022].
83-79-9.	Aggregated information to be made available to the public [Repealed effective July 1, 2022].
83-79-11.	Commissioner to promulgate rules to notify insurers of obligations under this chapter and clarify data requested and manner of production of data [Repealed effective July 1, 2022].
83-79-13.	Repeal of chapter.

§ 83-79-1. Short title [Repealed effective July 1, 2022].

(1) This chapter shall be known and may be cited as the Property Insurance Clarity Act.

(2) It is the intent and purpose of the Legislature that this chapter shall serve to allow the Mississippi Insurance Department to receive and aggregate insurers' homeowner claims loss data for the purposes of determining the accuracy and adequacy of catastrophic models and determine the adequacy of rates by data calls as prescribed in this chapter. This chapter is not intended to and shall not create any separate cause of action.

HISTORY: Laws, 2015, ch. 322, § 1, eff from and after July 1, 2015.

Editor's Notes — For repeal of this chapter, see § 83-79-13.

§ 83-79-3. Insurers authorized to transact homeowners insurance business in Mississippi required to provide certain policy and premium information to Department of Insurance; specific information to be provided [Repealed effective July 1, 2022].

(1)(a) Each insurance company and the Mississippi Windstorm Underwriting Association (herein after "insurers") authorized to transact homeowners insurance business in the State of Mississippi shall once every three (3) years submit to the Mississippi Insurance Department, commencing on or before October 1, 2015, for homeowners insurance policies, computations of the total amount of direct incurred losses, direct earned premiums, policy limits, reinsurance, allocated loss adjustment expense and the number of policies in force by earned house years for the prior calendar year.

(b) The insurers shall report the computations to the department by zip code.

(c) Such information shall be provided for each of the following policy categories:

(i) All homeowners policies that include windstorm coverage;

(ii) All homeowners policies that exclude windstorm coverage; and

(iii) All policies that only include windstorm coverage.

(d) The information received by the department shall be aggregated across all insurers collectively and the aggregated totals shall be arranged by zip code.

(e) Homeowners insurance policies shall include condominium insurance, dwelling fire policies, renters/tenants insurance and mobile home/manufactured housing property insurance.

(f) Creditor-placed property insurance, condominium association insurance and commercial insurance are excluded from this chapter.

(2) Based upon the information submitted to or otherwise gathered by the department, the department may post on the department website the aggregated total of the computations provided under subsection (1) of this section by zip code for the prior calendar year. The department may also post on the department website a general description of the rate-making methodology that the department allows insurers to use in establishing their homeowners rates.

(3) Each insurer authorized to transact homeowners insurance business in the state shall submit to the department catastrophe wind/hail information pursuant to a data call by the department based on a specific catastrophic event.

HISTORY: Laws, 2015, ch. 322, § 2, eff from and after July 1, 2015.

Editor's Notes — For repeal of this chapter, see § 83-79-13.

§ 83-79-5. Insurers authorized to transact homeowners insurance business in Mississippi required to provide certain policy and premium information to Department of Insurance for calendar years 2005 through 2014 [Repealed effective July 1, 2022].

No later than October 1, 2015, each insurer authorized to transact homeowners insurance business in this state shall provide the information required pursuant to Section 83-79-3(1), for the calendar years 2005 through 2014. Voluntary submissions of the information required by Section 83-79-3(1) for calendar years prior to 2005, may be submitted and shall be compiled by the department and may be posted by the department on the department website in the same manner. Based upon the submitted information, the department shall compile aggregate totals, commencing with calendar year 2005, and may post those aggregate totals on the department website pursuant to Section 83-79-3(2).

HISTORY: Laws, 2015, ch. 322, § 3, eff from and after July 1, 2015.

Editor's Notes — For repeal of this chapter, see § 83-79-13.

§ 83-79-7. Waiver, modification or extension for an additional time period of the reporting requirements; penalty for noncompliance with reporting requirements [Repealed effective July 1, 2022].

(1) Upon written request of an insurer, the commissioner may waive, modify, or extend for an additional time period, for good cause shown, the reporting requirements imposed by this chapter. The request shall demonstrate good cause for waiving, modifying, or extending the reporting requirements. Good cause may include, but is not limited to, the insurer's limited percentage of the total homeowners insurance market in this state, or the undue burden of compiling and reporting the computations, data, and other information required by this chapter due to the manner, format, or method in which the insurer has stored the computations, data, or other information required.

(2) Any insurer that fails to timely comply with the reporting requirements imposed by this chapter shall be given notice by the department of such failure and provided ninety (90) days within which to comply. Any insurer that fails to comply on or before the ninetieth day shall be fined Two Thousand Five Hundred Dollars ($2,500.00) per month by the department until the date of compliance. Any funds collected pursuant to this subsection shall be deposited into the Municipal Fire Protection Fund.

HISTORY: Laws, 2015, ch. 322, § 4, eff from and after July 1, 2015.

Editor's Notes — For repeal of this chapter, see § 83-79-13.

§ 83-79-9. Aggregated information to be made available to the public [Repealed effective July 1, 2022].

(1) Any information submitted to the department by an insurer pursuant to this chapter shall be reported to the department pursuant to the market analysis provisions in Section 83-5-205(4). Further, pursuant to Section 83-5-209(7), all data reported to the commissioner or his designee as part of this market analysis shall also be considered as confidential and privileged materials and afforded all protections from disclosure allowed under Section 83-5-209(7).

(2) Once the information from all of the insurers is aggregated, such aggregated information is not a commercially valuable trade secret or otherwise confidential and the department shall provide such information in a digital format in accordance with this chapter upon the request of any person

as provided in Section 25-61-1 et seq., but shall not release any company specific data.

HISTORY: Laws, 2015, ch. 322, § 5, eff from and after July 1, 2015.

Editor's Notes — For repeal of this chapter, see § 83-79-13.

§ 83-79-11. Commissioner to promulgate rules to notify insurers of obligations under this chapter and clarify data requested and manner of production of data [Repealed effective July 1, 2022].

(1) The commissioner shall promulgate rules consistent with this chapter to notify insurers of their obligations under this chapter and to clarify the data requested and the manner of production of such data.

(2) The commissioner may add any and all reasonable data to the data calls created by this chapter, and all such data shall be controlled by this chapter.

(3) The commissioner may prepare a report on the aggregate data collected that may give his findings and conclusions, which shall be a public record. Any such report shall not disclose the individual data of any insurer.

(4) The commissioner may assess costs to insurers for the cost incurred by the commissioner for outside experts and consultants in preparing the data calls and analysis of the aggregate data, and such costs shall be assessed to the insurers on a pro rata basis based on average premium volume for the last five (5) years for the insurance being surveyed.

(5) Nothing in this chapter shall limit the powers and duties of the department and commissioner as provided in other laws.

HISTORY: Laws, 2015, ch. 322, § 6, eff from and after July 1, 2015.

Editor's Notes — For repeal of this chapter, see § 83-79-13.

§ 83-79-13. Repeal of chapter.

This chapter shall stand repealed from and after July 1, 2022.

HISTORY: Laws, 2015, ch. 322, § 7, eff from and after July 1, 2015.

CHAPTER 81.

MISSISSIPPI DIRECT PRIMARY CARE ACT

Sec.	
83-81-1.	Short title.
83-81-3.	Definitions.
83-81-5.	Direct primary care agreement not an insurance product.
83-81-7.	Primary care provider not required to obtain license under this chapter to market or sell direct primary care agreement.
83-81-9.	Direct primary care agreement requirements; disclaimer.
83-81-11.	Acceptance or discontinuation of patients.

§ 83-81-1. Short title.

This chapter shall be known as the "Mississippi Direct Primary Care Act."

HISTORY: Laws, 2015, ch. 369, § 1, eff from and after July 1, 2015.

§ 83-81-3. Definitions.

As used in this chapter, the following words and phrases have the meanings as defined in this section unless the context clearly indicates otherwise:

(a) "Primary care provider" means an individual or other legal entity that is licensed, registered or otherwise authorized to provide primary care services in this state under Chapter 25, Title 73, Mississippi Code of 1972. Primary care provider includes an individual or other legal entity alone or with others professionally associated with the individual or other legal entity.

(b) "Direct primary care agreement" means a contract between a primary care provider and an individual patient or his or her legal representative or between a primary care provider and an employer on behalf of its employees in which the primary care provider agrees to provide primary care services to the individual patient for an agreed-upon fee and period of time.

(c) "Direct primary care service" means a service that is provided by charging a periodic fee-for-services; not billing any third parties on a fee-for-service basis for the individual covered by the direct primary care agreement; and allowing for a per visit fee to be charged to the patient at the time of service.

(d) "Primary care service" includes, but is not limited to, the screening, assessment, diagnosis, and treatment for the purpose of promotion of health or the detection and management of disease or injury within the competency, training, and scope of the primary care provider. This may also include fees for advanced technology or techniques used within the practice that may offer benefits for improved patient engagement.

HISTORY: Laws, 2015, ch. 369, § 2, eff from and after July 1, 2015.

§ 83-81-5. Direct primary care agreement not an insurance product.

A direct primary care agreement shall not be considered to be an insurance product nor shall the primary care provider be considered to be engaging in the business of insurance for the purpose of this Title 83, Mississippi Code of 1972.

HISTORY: Laws, 2015, ch. 369, § 3, eff from and after July 1, 2015.

§ 83-81-7. Primary care provider not required to obtain license under this chapter to market or sell direct primary care agreement.

A primary care provider or agent of a primary care provider is not required to obtain a certificate of authority or license under this chapter to market, sell, or offer to sell a direct primary care agreement.

HISTORY: Laws, 2015, ch. 369, § 4, eff from and after July 1, 2015.

§ 83-81-9. Direct primary care agreement requirements; disclaimer.

To offer a direct primary care service, the primary care provider must obtain a completed direct primary care agreement for each patient obtaining direct primary care services. In order to be considered a direct primary care agreement for the purposes of this section, the direct primary care agreement must meet all of the following requirements:

(a) Be in writing;

(b) Be signed by the individual patient or his or her legal representative and be made available for the records of the primary care provider or agent of the primary care provider;

(c) Allow either party to terminate the agreement on written notice to the other party;

(d) Describe the scope of primary care services that are covered by the periodic fee;

(e) Specify the periodic fee for ongoing care under the agreement;

(f) Specify the duration of the agreement, any automatic renewal periods, and prohibit the prepayment of the agreement. Upon discontinuing the agreement, all unearned funds, as determined by the lesser of normal undiscounted fee-for-service charges that would have been billed in place of the agreement or the remainder of the membership contract, are returned to the patient. Upon termination of the agreement, the patient shall not be liable for the remainder of payment associated with the agreement or membership contract. However, the patient shall be responsible for the true cost of services rendered regardless of when the contract is terminated.

(g) Prominently state in writing the following:

(i) That the agreement is not health insurance;

(ii) That the agreement standing alone does not satisfy the health benefit requirements as established in the federal Affordable Care Act; and

(iii) That, without adequate insurance coverage in addition to this agreement, the patient may be subject to fines and penalties associated with the federal Affordable Care Act.

HISTORY: Laws, 2015, ch. 369, § 5, eff from and after July 1, 2015.

Federal Aspects — Patient Protection and Affordable Care Act, see Pub. L. No. 111-148, 124 Stat. 119.

§ 83-81-11. Acceptance or discontinuation of patients.

Those primary care providers who offer direct primary care services to their patients may not decline to accept new direct primary care patients or discontinue care to existing patients solely because of the patient's health status. A direct primary care provider may decline to accept a patient if the practice has reached its maximum capacity, or if the patient's medical condition is such that the provider is unable to provide the appropriate level and type of primary care services the patient requires. So long as the direct primary care provider provides the patient notice and opportunity to obtain care from another physician, the direct primary care provider may discontinue care for direct primary care patients if:

(a) The patient fails to pay the periodic fee;

(b) The patient has performed an act of fraud;

(c) The patient repeatedly fails to adhere to the recommended treatment plan;

(d) The patient is abusive and presents an emotional or physical danger to the staff or other patients of the direct practice;

(e) The direct primary care provider discontinues operation as a direct primary care provider; or

(f) The direct primary care physician feels that the relationship is no longer therapeutic for the patient due to a dysfunctional physician/patient relationship.

HISTORY: Laws, 2015, ch. 369, § 6, eff from and after July 1, 2015.

CHAPTER 83.

TRAVEL INSURANCE ACT

Sec.

83-83-1.	Short title.
83-83-2.	Scope and purposes.
83-83-3.	Definitions.
83-83-5.	Requirements.
83-83-6.	Premium tax.
83-83-7.	Registration.
83-83-8.	Travel protection plans.
83-83-9.	Policy.
83-83-10.	Travel administrator.
83-83-11.	Responsibility.
83-83-13.	Sales practices.
83-83-15.	Regulations.

§ 83-83-1. Short title.

This chapter shall be known as the "Travel Insurance Act."

HISTORY: Laws, 2015, ch. 347, § 1, eff from and after Jan. 1, 2016; Laws, 2022, ch. 357, § 1, eff from and after July 1, 2022.

Amendment Notes. — The 2022 amendment deleted "Limited Lines" preceding "Travel."

§ 83-83-2. Scope and purposes.

(1) The purpose of this chapter is to promote the public welfare by creating a comprehensive legal framework within which travel insurance may be sold in this state.

(2) The requirements of this chapter shall apply to travel insurance which covers any resident of this state, sold, solicited, negotiated, or offered in this state and where policies and certificates are delivered or issued for delivery in this state. It shall not apply to cancellation fee waivers and travel assistance services, except as expressly provided herein.

(3) All other applicable provisions of this state's insurance laws shall continue to apply to travel insurance, except that the specific provisions of this chapter shall supersede any general provisions of law that would otherwise be applicable to travel insurance.

HISTORY: Laws, 2022, ch. 357, § 2, eff from and after July 1, 2022.

§ 83-83-3. Definitions.

As used in this chapter, unless the context otherwise requires:

(a) "Aggregator site" means a website that provides access to information regarding insurance products from more than one (1) insurer, including product and insurer information, for use in comparison shopping.

(b) "Blanket travel insurance" means a policy of travel insurance issued to any eligible group providing coverage for specific classes of persons defined in the policy with coverage provided to all members of the eligible group without a separate charge to individual members of the eligible group.

(c) "Cancellation fee waiver" means a contractual agreement between a supplier of travel services and its customer to waive some or all of the nonrefundable cancellation fee provisions of the supplier's underlying travel contract with or without regard to the reason for the cancellation or form of reimbursement. A cancellation fee waiver is not insurance.

(d) "Commissioner" means the Commissioner of Insurance for the State of Mississippi.

(e) "Eligible group" means, solely for the purposes of travel insurance, two (2) or more persons who are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, including, but not limited to, any of the following:

(i) Any entity engaged in the business of providing travel or travel services, including, but not limited to: tour operators, lodging providers, vacation property owners, hotels and resorts, travel clubs, travel agencies, property managers, cultural exchange programs, and common carriers or the operator, owner, or lessor of a means of transportation of passengers, including, but not limited to, airlines, cruise lines, railroads, steamship companies, and public bus carriers, wherein with regard to any particular travel or type of travel or travelers, all members or customers of the group must have a common exposure to risk attendant to such travel;

(ii) Any college, school, or other institution of learning covering students, teachers or employees or volunteers;

(iii) Any employer covering any group of employees, volunteers, contractors, board of directors, dependents or guests;

(iv) Any sports team, camp, or sponsor thereof covering participants, members, campers, employees, officials, supervisors or volunteers;

(v) Any religious, charitable, recreational, educational, or civic organization or branch thereof covering any group of members, participants or volunteers;

(vi) Any financial institution or financial institution vendor, or parent holding company, trustee, or agent of or designated by one or more financial institutions or financial institution vendors, including accountholders, credit card holders, debtors, guarantors or purchasers;

(vii) Any incorporated or unincorporated association, including labor unions, having a common interest, constitution and bylaws, and organized and maintained in good faith for purposes other than obtaining insurance for members or participants of such association covering its members;

(viii) Any trust or the trustees of a fund established, created or maintained for the benefit of and covering members, employees or customers, subject to the commissioner's permitting the use of a trust and the state's premium tax provisions in Section 83-83-6 of one or more associations meeting the above requirements of subparagraph (vii) of this paragraph (e);

(ix) Any entertainment production company covering any group of participants, volunteers, audience members, contestants or workers;

(x) Any volunteer fire department, ambulance, rescue, police, court or any first aid, civil defense or other such volunteer group;

(xi) Preschools, daycare institutions for children or adults, and senior citizen clubs;

(xii) Any automobile or truck rental or leasing company covering a group of individuals who may become renters, lessees, or passengers defined by their travel status on the rented or leased vehicles. The common carrier, the operator, owner, or lessor of a means of transportation, or the automobile or truck rental or leasing company, is the policyholder under a policy to which this section applies; or

(xiii) Any other group where the commissioner has determined that the members are engaged in a common enterprise, or have an economic, educational, or social affinity or relationship, and that issuance of the policy would not be contrary to the public interest.

(f) "Fulfillment materials" means documentation sent to the purchaser of a travel protection plan confirming the purchase and providing the travel protection plan's coverage and assistance details.

(g) "Group travel insurance" means travel insurance issued to any eligible group.

(h) "Limited lines travel insurance producer" means a:

(i) Licensed managing general agent or third-party administrator;

(ii) Licensed insurance producer, including a limited lines producer designated by an insurer as the travel insurance supervising entity as set forth in Section 83-83-11; or

(iii) Travel administrator.

(i) "Offer and disseminate" means providing general information, including a description of the coverage and price, as well as processing the application and collecting premiums, and performing other nonlicensable activities permitted by the state.

(j) "Primary certificate holder," specific to Section 83-83-6, means an individual person who elects and purchases travel insurance under a group policy.

(k) "Primary policyholder," specific to Section 83-83-6, means an individual person who elects and purchases individual travel insurance.

(*l*) "Travel administrator" means a person who directly or indirectly underwrites, collects charges, collateral, or premiums from, or adjusts or settles claims on residents of this state, in connection with travel insurance, except that a person shall not be considered a travel administrator if that person's only actions that would otherwise cause it to be considered a travel administrator are among the following:

(i) A person working for a travel administrator to the extent that the person's activities are subject to the supervision and control of the travel administrator;

(ii) An insurance producer selling insurance or engaged in administrative and claims-related activities within the scope of the producer's license;

(iii) A travel retailer offering and disseminating travel insurance and registered under the license of a limited lines travel insurance producer in accordance with this chapter;

(iv) An individual adjusting or settling claims in the normal course of that individual's practice or employment as an attorney-at-law and who does not collect charges or premiums in connection with insurance coverage; or

(v) A business entity that is affiliated with a licensed insurer while acting as a travel administrator for the direct and assumed insurance business of an affiliated insurer.

(m) "Travel assistance services" means noninsurance services for which the consumer is not indemnified based on a fortuitous event, and where providing the service does not result in the transfer or shifting of risk that would constitute the business of insurance. Travel assistance services include, but are not limited to: security advisories; destination information; vaccination and immunization information services; travel reservation services; entertainment; activity and event planning; translation assistance; emergency messaging; international legal and medical referrals; medical case monitoring; coordination of transportation arrangements; emergency cash transfer assistance; medical prescription replacement assistance; passport and travel document replacement assistance; lost luggage assistance; concierge services; and any other service that is furnished in connection with planned travel. Travel assistance services are not insurance and not related to insurance.

(n) "Travel insurance" means insurance coverage for personal risks incident to planned travel, including, but not limited to:

(i) Interruption or cancellation of trip or event;

(ii) Loss of baggage or personal effects;

(iii) Damages to accommodations or rental vehicles;

(iv) Sickness, accident, disability or death occurring during travel;

(v) Emergency evacuation;

(vi) Repatriation of remains; or

(vii) Any other contractual obligations to indemnify or pay a specified amount to the traveler upon determinable contingencies related to travel as approved by the commissioner.

Travel insurance does not include major medical plans that provide comprehensive medical protection for travelers with trips lasting longer than six (6) months, including, for example, those working or residing overseas as an expatriate or military personnel being deployed, or any other product that requires a specific insurance producer license.

(o) "Travel protection plans" means plans that provide one or more of the following: travel insurance, travel assistance services, and cancellation fee waivers.

(p) "Travel retailer" means a business entity that makes, arranges, or offers planned travel and may offer and disseminate travel insurance as a service to its customers on behalf of and under the direction of a limited lines travel insurance producer.

HISTORY: Laws, 2015, ch. 347, § 2, eff from and after Jan. 1, 2016; Laws, 2022, ch. 357, § 3, eff from and after July 1, 2022.

Amendment Notes — The 2022 amendment added (a) through (c); redesignated former (a) as (d); added (e) through (g); redesignated former (b) as (h), and therein added (iii) and made a related change; redesignated former (c) as (i); added (j) through (m); rewrote and redesignated former (d) as (n); added (o); and redesignated former (e) as (p), and therein inserted "planned" preceding "travel" and deleted "services" thereafter.

§ 83-83-5. Requirements.

Notwithstanding any other provision of law:

(a) The commissioner may issue to an individual or business entity that has filed with the commissioner an application for such limited license in a form and manner prescribed by the commissioner, a limited lines travel insurance producer license which authorizes the limited lines travel insurance producer to sell, solicit or negotiate travel insurance through a licensed insurer. No person may act as a limited lines travel insurance producer or travel insurance retailer unless properly licensed or registered, respectively.

(b) A travel retailer may offer and disseminate travel insurance under a limited lines travel insurance producer business entity ("licensed business entity") license only if the following conditions are met:

(i) The limited lines travel insurance producer or travel retailer provides to purchasers of travel insurance:

1. A description of the material terms or the actual material terms of the insurance coverage;

2. A description of the process for filing a claim;

3. A description of the review or cancellation process for the travel insurance policy; and

4. The identity and contact information of the insurer and limited lines travel insurance producer.

(ii) At the time of licensure, the limited lines travel insurance producer shall establish and maintain a register on a form prescribed by the commissioner of each travel retailer that offers travel insurance on the limited lines travel insurance producer's behalf. The register shall be maintained and updated by the limited lines travel insurance producer and shall include the name, address and contact information of the travel retailer and an officer or person who directs or controls the travel retailer's operations, and the travel retailer's federal tax identification number. The limited lines travel insurance producer shall submit such register to the Department of Insurance upon reasonable request. The limited lines travel insurance producer shall also certify that the travel retailer registered complies with 18 USC 1033. The grounds for the suspension, revocation, and the penalties applicable to resident insurance producers shall be applicable to the limited lines travel insurance producers and travel retailers.

(iii) The limited lines travel insurance producer has designated one of its employees who is a licensed individual producer as the person (a "designated responsible producer" or "DRP") responsible for the limited lines travel insurance producer's compliance with the travel insurance laws, rules and regulations of the state.

(iv) The DRP, president, secretary, treasurer, and any other officer or person who directs or controls the limited lines travel insurance producer's insurance operations comply with the fingerprinting requirements applicable to insurance producers in the resident state of the limited lines travel insurance producer.

(v) The limited lines travel insurance producer has paid all applicable insurance producer licensing fees as set forth in applicable state law.

(vi) The limited lines travel insurance producer requires each employee and authorized representative of the travel retailer whose duties include offering and disseminating travel insurance to receive a program of instruction or training, which may be subject to review and approval by the commissioner. The training material shall, at a minimum, contain instructions on the types of insurance offered, ethical sales practices, and required disclosures to prospective customers.

(vii) Limited lines travel insurance producers, and those registered under their license, are exempt from the examination requirements and the continuing education requirements of Chapter 17 of Title 83, Mississippi Code of 1972.

(c) Any travel retailer offering or disseminating travel insurance shall make available to prospective purchasers brochures or other written materials that have been approved by the travel insurer. Such materials shall include information which, at a minimum:

(i) Provides the identity and contact information of the insurer and the limited lines travel insurance producer;

(ii) Explains that the purchase of travel insurance is not required in order to purchase any other product or service from the travel retailer; and

(iii) Explains that an unlicensed travel retailer is permitted to provide general information about the insurance offered by the travel retailer, including a description of the coverage and price, but is not qualified or authorized to answer technical questions about the terms and conditions of the insurance offered by the travel retailer or to evaluate the adequacy of the customer's existing insurance coverage.

(d) A travel retailer's employee or authorized representative, who is not licensed as an insurance producer, may not:

(i) Evaluate or interpret the technical terms, benefits and conditions of the offered travel insurance coverage;

(ii) Evaluate or provide advice concerning a prospective purchaser's existing insurance coverage; or

(iii) Hold himself or itself out as a licensed insurer, licensed producer, or insurance expert.

(e) Any person licensed in a major line of authority as an insurance producer is authorized to sell, solicit and negotiate travel insurance. A property and casualty insurance producer is not required to become appointed by an insurer in order to sell, solicit or negotiate travel insurance.

HISTORY: Laws, 2015, ch. 347, § 3, eff from and after Jan. 1, 2016; Laws, 2022, ch. 357, § 4, eff from and after July 1, 2022.

Amendment Note — The 2022 amendment, in (a), added the last sentence; in (b), added the last sentence in (ii), and inserted "and approval" in the first sentence of (vi); in (c), added "have been approved by the travel insurer" in the first sentence, and added the last sentence; added (e); and made minor stylistic changes.

§ 83-83-6. Premium tax.

(1) A travel insurer shall pay a premium tax, as provided in Section 27-15-103 or Section 27-15-109, on travel insurance premiums paid by any of the following:

(a) An individual primary policyholder who is a resident of this state;

(b) A primary certificate holder who is a resident of this state who elects coverage under a group travel insurance policy; or

(c) A blanket travel insurance policyholder that is a resident in, or has its principal place of business or the principal place of business of an affiliate or subsidiary that has purchased blanket travel insurance in, this state for eligible blanket group members, subject to any apportionment rules which apply to the insurer across multiple taxing jurisdictions or that permits the insurer to allocate premium on an apportioned basis in a reasonable and equitable manner in those jurisdictions.

(2) A travel insurer shall:

(a) Document the state of residence or principal place of business of the policyholder or certificate holder, as required in subsection (1) of this section; and

(b) Report as premium only the amount allocable to travel insurance and not any amounts received for travel assistance services or cancellation fee waivers.

HISTORY: Laws, 2022, ch. 357, § 5, eff from and after July 1, 2022.

Joint Legislative Committee Note — Pursuant to Section 1-1-109, the Joint Legislative Committee on Compilation, Revision and Publication of Legislation inserted "a" preceding "premium tax" near the beginning of (1). The Joint Committee ratified the correction at its August 10, 2022, meeting.

§ 83-83-7. Registration.

Notwithstanding any other provision in law, a travel retailer whose insurance-related activities, and those of its employees and authorized representatives, are limited to offering and disseminating travel insurance on behalf of and under the direction of a limited lines travel insurance producer meeting the conditions stated in this chapter, is authorized to do so and receive related compensation, upon registration by the limited lines travel insurance producer as described in Section 83-83-5(b)(ii).

HISTORY: Laws, 2015, ch. 347, § 4, eff from and after Jan. 1, 2016.

§ 83-83-8. Travel protection plans.

Travel protection plans may be offered for one (1) price for the combined features that the travel protection plan offers in this state if:

(a) The travel protection plan clearly discloses to the consumer at or prior to the time of purchase that it includes travel insurance, travel assistance services, and cancellation fee waivers as applicable, and provides information and an opportunity at or prior to the time of purchase for the consumer to obtain additional information regarding the features and pricing of each; and

(b) The fulfillment materials:

(i) Describe and delineate the travel insurance, travel assistance services, and cancellation fee waivers in the travel protection plan; and

(ii) Include the travel insurance disclosures and the contact information for persons providing travel assistance services and cancellation fee waivers, as applicable.

HISTORY: Laws, 2022, ch. 357, § 6, eff from and after July 1, 2022.

§ 83-83-9. Policy.

(1) Notwithstanding any other provision of this title, travel insurance shall be classified and filed for purposes of rates and forms under an inland marine line of insurance; provided, however, that travel insurance that provides coverage for sickness, accident, disability or death occurring during travel, either exclusively or in conjunction with related coverages of emergency evacuation or repatriation of remains, or incidental limited property and casualty benefits such as baggage or trip cancellation, may be filed by an authorized insurer under either an accident and health line of insurance or an inland marine line of insurance.

(2) Travel insurance may be provided under an individual group or blanket policy.

(3) Eligibility and underwriting standards for travel insurance may be developed and provided based on travel protection plans designed for individual or identified marketing or distribution channels, provided those standards also meet the state's underwriting standards for inland marine.

HISTORY: Laws, 2015, ch. 347, § 5, eff from and after Jan. 1, 2016; Laws, 2022, ch. 357, § 7, eff from and after July 1, 2022.

Amendment Note — The 2022 amendment, added (1) and (3); and rewrote (2), which read: "Travel insurance may be provided under an individual policy or under a group or master policy."

§ 83-83-10. Travel administrator.

(1) Notwithstanding any other provisions of this title, no person shall act or represent itself as a travel administrator for travel insurance in this state unless that person:

(a) Is a licensed property and casualty insurance producer in this state for activities permitted under that producer license;

(b) Holds a valid managing general agent ("MGA") license in this state; or

(c) Holds a valid third-party administrator ("TPA") license in this state.

(2) A travel administrator and its employees are exempt from the licensing requirements of Section 83-17-401 et seq. for travel insurance it administers.

(3) An insurer is responsible for the acts of a travel administrator administering travel insurance underwritten by the insurer, and is responsible for ensuring that the travel administrator maintains all books and records relevant to the insurer to be made available by the travel administrator to the commissioner upon request.

HISTORY: Laws, 2022, ch. 357, § 8, eff from and after July 1, 2022.

§ 83-83-11. Responsibility.

As the insurer designee, the limited lines travel insurance producer is responsible for the acts of the travel retailer and shall use reasonable means to ensure compliance by the travel retailer with this chapter.

HISTORY: Laws, 2015, ch. 347, § 6, eff from and after Jan. 1, 2016.

§ 83-83-13. Sales practices.

(1) The limited lines travel insurance producer and any travel retailer offering and disseminating travel insurance under the limited lines travel insurance producer license shall be subject to the provisions of Sections 83-5-29 through 83-5-51 and Section 83-17-71, except as otherwise provided in this section. In the event of a conflict between this chapter and other provisions of this title regarding the sale and marketing of travel insurance and travel protection plans, the provisions of this chapter shall control.

(2) Offering or selling a travel insurance policy that could never result in payment of any claims for any insured under the policy is an unfair trade practice under Sections 83-5-29 through 83-5-51.

(3)(a) All documents provided to consumers prior to the purchase of travel insurance, including, but not limited to, sales materials, advertising materials, and marketing materials, shall be consistent with the travel insurance policy itself, including, but not limited to, forms, endorsements, policies, rate filings, and certificates of insurance.

(b) For travel insurance policies or certificates that contain preexisting condition exclusions, information and an opportunity to learn more about the preexisting condition exclusions shall be provided any time prior to the time of purchase, and in the coverage's fulfillment materials.

(c) The fulfillment materials and the information described in Section 83-83-5(b)(i)1 through 4 shall be provided to a policyholder or certificate holder as soon as practicable following the purchase of a travel protection plan. Unless the insured has either started a covered trip or filed a claim under the travel insurance coverage, a policyholder or certificate holder may cancel a policy or certificate for a full refund of the travel protection plan price from the date of purchase of a travel protection plan until at least:

(i) Fifteen (15) days following the date of delivery of the travel protection plan's fulfillment materials by postal mail; or

(ii) Ten (10) days following the date of delivery of the travel protection plan's fulfillment materials by means other than postal mail.

For the purposes of this section, delivery means handing fulfillment materials to the policyholder or certificate holder or sending fulfillment materials by postal mail or electronic means to the policyholder or certificate holder.

(d) The company shall disclose in the policy documentation and fulfillment materials whether the travel insurance is primary or secondary to other applicable coverage.

(e) Where travel insurance is marketed directly to a consumer through an insurer's website or by others through an aggregator site, it shall not be an unfair trade practice or other violation of law where an accurate summary or short description of coverage is provided on the web page, so long as the consumer has access to the full provisions of the policy through electronic means.

(4) No person offering, soliciting, or negotiating travel insurance or travel protection plans on an individual or group basis may do so by using negative option or opt out, which would require a consumer to take an affirmative action to deselect coverage such as unchecking a box on an electronic form when the consumer purchases a trip.

(5) It shall be an unfair trade practice to market blanket travel insurance coverage as free.

(6) Where a consumer's destination jurisdiction requires insurance coverage, it shall not be an unfair trade practice to require that a consumer choose between the following options as a condition of purchasing a trip or travel package:

(a) Purchasing the coverage required by the destination jurisdiction through the travel retailer or limited lines travel insurance producer supplying the trip or travel package; or

(b) Agreeing to obtain and provide proof of coverage that meets the destination jurisdiction's requirements prior to departure.

HISTORY: Laws, 2015, ch. 347, § 7, eff from and after Jan. 1, 2016; Laws, 2022, ch. 357, § 9, eff from and after July 1, 2022.

Amendment Notes — The 2022 amendment, in (1), added the exception in the first sentence, and added the last sentence; and added (2) through (6).

§ 83-83-15. Regulations.

The Commissioner of Insurance may promulgate regulations to implement the provisions of this chapter.

HISTORY: Laws, 2022, ch. 357, § 10, eff from and after July 1, 2022.

CHAPTER 85.

OWN RISK AND SOLVENCY ASSESSMENT ACT

Sec.

83-85-1. Title.
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§ 83-85-1. Title.

This chapter shall be known and may be cited as the "Own Risk and Solvency Assessment Act."

HISTORY: Laws, 2017, ch. 306, § 11, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-3. Own Risk and Solvency Assessment (ORSA) purpose and scope.

The purpose of this chapter is to provide the requirements for maintaining a risk management framework and completing an Own Risk and Solvency Assessment (ORSA) and provide guidance and instructions for filing an ORSA Summary Report with the insurance commissioner of this state. The requirements of this chapter shall apply to all insurers domiciled in this state unless exempt pursuant to Section 83-85-13.

HISTORY: Laws, 2017, ch. 306, § 12, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-5. Definitions.

As used in this chapter, the following words shall have the meaning ascribed herein unless the context clearly requires otherwise:

(a) "Insurance group" means, for the purpose of conducting an ORSA, those insurers and affiliates included within an insurance holding company system as defined in Section 83-6-1(d).

(b) "Insurer" shall have the same meaning as set forth in Section 83-6-1(e), except that it shall not include agencies, authorities or instrumentalities of the United States, its possessions and territories, the Commonwealth of Puerto Rico, the District of Columbia, or a state or political subdivision of a state.

(c) "Own Risk and Solvency Assessment" or "ORSA" means a confidential internal assessment, appropriate to the nature, scale and complexity of an insurer or insurance group, conducted by that insurer or insurance group of the material and relevant risks associated with the insurer or insurance group's current business plan, and the sufficiency of capital resources to support those risks.

(d) "ORSA Guidance Manual" means the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners (NAIC) and as amended from time to time. A change in the ORSA Guidance Manual shall be effective on the January 1 following the calendar year in which the changes have been adopted by the NAIC.

(e) "ORSA Summary Report" means a confidential high-level summary of an insurer or insurance group's ORSA.

HISTORY: Laws, 2017, ch. 306, § 13, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-7. Risk management framework.

An insurer shall maintain a risk management framework to assist the insurer with identifying, assessing, monitoring, managing and reporting on its material and relevant risks. This requirement may be satisfied if the insurance group of which the insurer is a member maintains a risk management framework applicable to the operations of the insurer.

HISTORY: Laws, 2017, ch. 306, § 14, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-9. ORSA requirement.

Subject to Section 83-85-13, an insurer, or the insurance group of which the insurer is a member, shall regularly conduct an ORSA consistent with a process comparable to the ORSA Guidance Manual. The ORSA shall be conducted no less than annually but also at any time when there are significant changes to the risk profile of the insurer or the insurance group of which the insurer is a member.

HISTORY: Laws, 2017, ch. 306, § 15, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-11. ORSA Summary Report.

(1) Upon the commissioner's request, and no more than once each year, an insurer shall submit to the commissioner an ORSA Summary Report or any combination of reports that together contain the information described in the ORSA Guidance Manual, applicable to the insurer and/or the insurance group of which it is a member. Notwithstanding any request from the commissioner, if the insurer is a member of an insurance group, the insurer shall submit the report(s) required by this subsection if the commissioner is the lead state commissioner of the insurance group as determined by the procedures within the Financial Analysis Handbook adopted by the National Association of Insurance Commissioners.

(2) The report(s) shall include a signature of the insurer or insurance group's chief risk officer or other executive having responsibility for the oversight of the insurer's enterprise risk management process attesting to the best of his/her belief and knowledge that the insurer applies the enterprise risk management process described in the ORSA Summary Report and that a copy of the report has been provided to the insurer's board of directors or the appropriate committee thereof.

(3) An insurer may comply with subsection (1) by providing the most recent and substantially similar report(s) provided by the insurer or another member of an insurance group of which the insurer is a member to the commissioner of another state or to a supervisor or regulator of a foreign jurisdiction, if that report provides information that is comparable to the information described in the ORSA Guidance Manual. Any such report in a language other than English must be accompanied by a translation of that report into the English language.

HISTORY: Laws, 2017, ch. 306, § 16, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as this section]."

§ 83-85-13. Exemption.

(1) An insurer shall be exempt from the requirements of this chapter, if:

(a) The insurer has annual direct written and unaffiliated assumed premium, including international direct and assumed premium but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than Five Hundred Million Dollars ($500,000,000.00); and

(b) The insurance group of which the insurer is a member has annual direct written and unaffiliated assumed premium including international direct and assumed premium, but excluding premiums reinsured with the Federal Crop Insurance Corporation and Federal Flood Program, less than One Billion Dollars ($1,000,000,000.00).

(2) If an insurer qualifies for exemption pursuant to paragraph (a) of subsection (1), but the insurance group of which the insurer is a member does not qualify for exemption pursuant to paragraph (b) of subsection (1), then the ORSA Summary Report that may be required pursuant to Section 83-85-11 shall include every insurer within the insurance group. This requirement may be satisfied by the submission of more than one ORSA Summary Report for any combination of insurers provided any combination of reports includes every insurer within the insurance group.

(3) If an insurer does not qualify for exemption pursuant to paragraph (a) of subsection (1), but the insurance group of which it is a member qualifies for exemption pursuant to paragraph (b) of subsection (1), then the only ORSA Summary Report that may be required pursuant to Section 83-85-11 shall be the report applicable to that insurer.

(4) An insurer that does not qualify for exemption pursuant to subsection (1) may apply to the commissioner for a waiver from the requirements of this chapter based upon unique circumstances. In deciding whether to grant the insurer's request for waiver, the commissioner may consider the type and volume of business written, ownership and organizational structure, and any other factor the commissioner considers relevant to the insurer or insurance group of which the insurer is a member. If the insurer is part of an insurance group with insurers domiciled in more than one (1) state, the commissioner shall coordinate with the lead state commissioner and with the other domiciliary commissioners in considering whether to grant the insurer's request for a waiver.

(5) Notwithstanding the exemptions stated in this section:

(a) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA Summary

Report based on unique circumstances including, but not limited to, the type and volume of business written, ownership and organizational structure, federal agency requests, and international supervisor requests.

(b) The commissioner may require that an insurer maintain a risk management framework, conduct an ORSA and file an ORSA Summary Report if the insurer has Risk-Based Capital for company action level event as defined in Sections 83-5-401 through 83-5-427, meets one or more of the standards of an insurer deemed to be in hazardous financial condition as defined in Part 1, Chapter 39, Title 19 of the Mississippi Administrative Code, or otherwise exhibits qualities of a troubled insurer as determined by the commissioner.

(6) If an insurer that qualifies for an exemption pursuant to subsection (1) subsequently no longer qualifies for that exemption due to changes in premium as reflected in the insurer's most recent annual statement or in the most recent annual statements of the insurers within the insurance group of which the insurer is a member, the insurer shall have one (1) year following the year the threshold is exceeded to comply with the requirements of this chapter.

HISTORY: Laws, 2017, ch. 306, § 17, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-15. Contents of ORSA Summary Report.

(1) The ORSA Summary Report shall be prepared consistent with the ORSA Guidance Manual, subject to the requirements of subsection (2) of this section. Documentation and supporting information shall be maintained and made available upon examination or upon request of the commissioner.

(2) The review of the ORSA Summary Report, and any additional requests for information, shall be made using similar procedures currently used in the analysis and examination of multistate or global insurers and insurance groups.

HISTORY: Laws, 2017, ch. 306, § 18, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-17. Confidentiality.

(1) Documents, materials or other information, including the ORSA Summary Report, in the possession of or control of the Department of

Insurance that are obtained by, created by or disclosed to the commissioner or any other person under this chapter, is recognized by this state as being proprietary and to contain trade secrets. All such documents, materials or other information shall be confidential by law and privileged, shall not be subject to Sections 25-61-1 through 25-61-17, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. However, the commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the commissioner's official duties. The commissioner shall not otherwise make the documents, materials or other information public without the prior written consent of the insurer.

(2) Neither the commissioner nor any person who received documents, materials or other ORSA-related information, through examination or otherwise, while acting under the authority of the commissioner or with whom such documents, materials or other information are shared pursuant to this chapter shall be permitted or required to testify in any private civil action concerning any confidential documents, materials, or information subject to subsection (1) of this section.

(3) In order to assist in the performance of the commissioner's regulatory duties, the commissioner:

(a) May, upon request, share documents, materials or other ORSA-related information, including the confidential and privileged documents, materials or information subject to subsection (1) of this section, including proprietary and trade secret documents and materials with other state, federal and international financial regulatory agencies, including members of any supervisory college with the NAIC and with any third-party consultants designated by the commissioner, provided that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(b) May receive documents, materials or other ORSA-related information, including otherwise confidential and privileged documents, materials or information, including proprietary and trade-secret information or documents, from regulatory officials of other foreign or domestic jurisdictions, including members of any supervisory college and from the NAIC, and shall maintain as confidential or privileged any documents, materials or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(c) Shall enter into a written agreement with the NAIC or a third-party consultant governing sharing and use of information provided pursuant to this chapter, consistent with this subsection that shall:

(i) Specify procedures and protocols regarding the confidentiality and security of information shared with the NAIC or a third-party consultant pursuant to this chapter, including procedures and protocols for sharing by the NAIC with other state regulators from states in which the insurance group has domiciled insurers. The agreement shall provide that the recipient agrees in writing to maintain the confidentiality and privileged status of the ORSA-related documents, materials or other information and has verified in writing the legal authority to maintain confidentiality;

(ii) Specify that ownership of information shared with the NAIC or a third-party consultant pursuant to this chapter remains with the commissioner and the NAIC's or a third-party consultant's use of the information is subject to the direction of the commissioner;

(iii) Prohibit the NAIC or third-party consultant from storing the information shared pursuant to this chapter in a permanent database after the underlying analysis is completed;

(iv) Require prompt notice to be given to an insurer whose confidential information in the possession of the NAIC or a third-party consultant pursuant to this chapter is subject to a request or subpoena to the NAIC or a third-party consultant for disclosure or production;

(v) Require the NAIC or a third-party consultant to consent to intervention by an insurer in any judicial or administrative action in which the NAIC or a third-party consultant may be required to disclose confidential information about the insurer shared with the NAIC or a third-party consultant pursuant to this chapter; and

(vi) In the case of an agreement involving a third-party consultant, provide for the insurer's written consent.

(4) The sharing of information and documents by the commissioner pursuant to this chapter shall not constitute a delegation of regulatory authority or rulemaking, and the commissioner is solely responsible for the administration, execution and enforcement of the provisions of this chapter.

(5) No waiver of any applicable privilege or claim of confidentiality in the documents, proprietary and trade-secret materials or other ORSA-related information shall occur as a result of disclosure of such ORSA-related information or documents to the commissioner under this section or as a result of sharing as authorized in this chapter.

(6) Documents, materials or other information in the possession or control of the NAIC or a third-party consultants pursuant to this chapter shall be confidential by law and privileged, shall not be subject to the provisions of Section 25-61-1 through 25-61-17, shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action.

HISTORY: Laws, 2017, ch. 306, § 19, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-19. Sanctions.

Any insurer failing, without just cause, to timely file the ORSA Summary Report as required in this chapter shall be required, after notice and hearing, to pay a penalty of One Hundred Dollars ($100.00) for each day's delay, to be recovered by the commissioner and the penalty so recovered shall be paid into the General Revenue Fund of this state. The maximum penalty under this section is Ten Thousand Dollars ($10,000.00). The commissioner may reduce the penalty if the insurer demonstrates to the commissioner that the imposition of the penalty would constitute a financial hardship to the insurer.

HISTORY: Laws, 2017, ch. 306, § 20, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

§ 83-85-21. Severability clause.

If any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, such determination shall not affect the provisions or applications of this chapter which can be given effect without the invalid provision or application, and to that end the provisions of this chapter are severable.

HISTORY: Laws, 2017, ch. 306, § 21, eff from and after Jan. 1, 2018.

Editor's Notes — Laws of 2017, ch. 306, § 22, effective March 6, 2017, provides: "SECTION 22. This act shall take effect and be in force from and after its passage, except Sections 11 through 21 of this act [codified as Sections 83-85-1 through 83-85-21] shall take effect and be in force from and after January 1, 2018. The first filing of the ORSA Summary Report shall be in 2018 pursuant to Section 16 of this act [codified as Section 83-85-11]."

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